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Being the Incorporation of the Journals hitherto known as "The Medical Press" and "The Medical Circular."

A Weekly Journal

OF

MEDICINE AND MEDICAL AFFAIRS.

FROM JULY TO DECEMBER,

1905.

LONDON: 8 HENRIETTA STREET, STRAND; DUBLIN: 16 LINCOLN PLACE.

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"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, JULY 5, 1905. No. 1.

Original Communications.

THE PREVENTION OF CANCER

A LECTURE DELIVERED AT THE WEST LONDON POST-GRADUATE COLLEGE.

By C. B. KEETLEY, F.R.C.S.,
Senior Surgeon to the West London Hospital.

THE most able short statement of the position in which medical science stands with regard to cancer is an article in the *Times* of April 21st, 1902, entitled "The Investigation of Cancer." The author's final conclusion is that "we must force ourselves to wait." These words express the opinion of what might be looked up to as medical authorities at the present date. Certainly they express the views of the *Lancet* as well as of the *Times*. However, the former journal, with its accustomed fairness, permitted me four years ago (August 31st, 1901) to advance and support a contrary view, and I wish to develop this view now more completely for the followings reasons:—

(1) A single statement never attracts due attention in these days of energetic advertisement. It is not found sufficient even in the case of a quick remedy of an eye-striking description, while my recommendation was of unexciting methods which involved taking pains, a course to most people more objectionable even than spending money.

(2) My paper was quickly followed by recommendations from other medical men, who profoundly believed each in his own panacea, recommendations of so bizarre, not to say sensational, a kind that they practically "guyed" my argument and suggestions. I refer more especially to the paper read by Dr. James Braithwaite, of Leeds, on November 11th of the same year, entitled "Excess of Salt in the Diet a probable Factor in the Causation of Cancer."

(3) In looking over the literature of the subject since 1901, it appears to me that such authors as have paid any attention to my paper may be classified into those who have criticised it after reading my name and not reading my paper, and those who have read and made use of the paper, and a speech delivered at the West London Medico-Chirurgical Society without noticing my name at the head of them.

I hold that the time is now as ripe and as promising for the organisation of a system for the effective prevention of cancer as in 1870 it was ripe for the introduction by Lord Lister of a system for the prevention of the deadly complications of wounds in the presence of which the surgeons of those days stood nearly helpless. Nay, the times are even more ripe now, for four reasons:—(1) that Listerism has succeeded in its task; (2) that since it was introduced, mind not before, the glass makers, the optical instrument makers, and the bacteriologists, by successive improvements, which could not have been foreseen with confidence by any man in 1870, have made possible the discovery, demonstration, and biological study of the actual causes of the deadly infections of wounds, causes which Lister could surmise only; (3) that in spite of the extensive knowledge of these causes which an army of observers have now been accumulating for a generation, the surgeon still relies for the salvation of his patients on measures for the prevention of wound infection, and when he is driven to the use of sero-therapy falls back upon anti-streptococcus serum, and even tetanus antitoxin with feelings of no great confidence. (What if we had "forced ourselves to wait" in 1870 for the bacteriological discoveries which have now, after thirty-five years placed nothing in our hands except serums which are insufficient for general purposes of cure, however wonderful may be their occasional successes under favourable circumstances!) (4) That bacteriology, while it has done so little to help us to cure wound infections, has been of the greatest assistance in helping to study the precise and the comparative value of agents useful for the prevention of such maladies.

It is therefore plain that we are in a much better position to plan a system of disease prevention now than anyone was thirty-five years ago.

Yes! it may be replied, but Pasteur had demonstrated the nature of wound infections before that time, and Lister had only to devise a workable plan based on a theory already proved. This view is absolutely incorrect, although it has been put forward by writers who ought to know better They have evidently been misled by Lister's conscientious not to say generous habit of making full acknowledgment of his obligations to Pasteur. Nevertheless Pasteur paved the way for Lister, and I believe it will be found that, in a similar way those investigators and Koch have prepared the way for a practical system capable of preventing cancer. Pasteur and his predecessors had demonstrated the cause of putrefaction. But the micro-organisms which cause wound infections were not demonstrated until after the introduction of Listerism.

All depends on whether or not the materies morbi of cancer is or is not some living principle introduced into the stricken animal from without. It does not matter whether this materies be vegetable, like the bacillus of tubercle, or animal like the parasite in malaria, if bacteriology has proved anything it has proved that such principles or causes of disease cannot live long in the presence of degrees of heat lower than those required to make ordinary organic and inorganic substances cease to be useful as food.

Are then the grounds for attributing cancer to some living micro-organism strong or weak? For my part, I think they are overwhelmingly strong.

In the first place, nearly ALL diseases (as distinguished from injuries such as cuts, bruises, burns and the effects of mineral and vegetable poisons) are caused by bacteria. Let the mind run over an unselected list of the ailments with which both profession and the public are familiar, *e.g.*, nasal catarrh, sore throat, tonsillitis, toothache, enlarged glands in the neck, bronchitis, pneumonia, pleurisy, gastric catarrh, infantile diarrhœa, marasmus, appendicitis, peritonitis, acute rheumatism, various chronic rheumatisms, dysentery, typhoid, gall-stones, whooping-cough, measles, scarlatina, so-called "bilious attacks," aches of various kinds, *e.g.*, head-aches, stomach-aches, back-aches, aching of the limbs when accompanied by fever, and not due to mere fatigue; it is known of many of these and firmly believed of all or nearly all that they are caused by micro-organisms. For example, it is known that typhoid fever is due to the typhoid bacillus, and, although it is only recently, if at all, that the bacteriology of scarlatina has been positively demonstrated, I have not met for many years a single medical man who doubted the causation of that disease by living organisms of some sort. When we turn to those recognised constitutional diseases which present a certain parallelism to cancer, owing to the fact that they produce tumours and cause ulcerations and secondary growths, we see a group whose origin from living organisms is, if possible, more certain. The tubercle bacillus is well-known to everybody. The germs of actinomycosis, of glanders, and of leprosy are also demonstrated. There remains syphilis. The clinical evidence alone should leave no reasonable person in doubt about this being a germ-produced disease. It was this group of diseases by which, according to Sir James Paget, writing in 1887: "The conformity of cancer and cancerous diseases may be tested." After pointing out that Virchow placed the growths caused by these affections among tumours under the name of "granulomata," Paget remarked that a tuberculoma in the brain or a syphiloma in a muscle has more of the general characters of a tumour than a rodent ulcer or many cancers of the lip or tongue. Further, all are prone to special modes of degeneration and of ulceration. Those which break down the centre of a cancerous gland are sometimes so like those commonly found in tuberculous glands that no ordinary operative or clinical experience can distinguish them with confidence until a report has been obtained from a good pathologist. Whatever doubt may exist in some minds about the possibility of transmitting cancer from one person to another, there can be no question but that cancer is as infectious as tubercle, "by the invasion of adjacent parts or by the transmission of material." Further there are all degrees of malignancy alike in cancer, in tubercle, and in syphilis, if we use the term malignant in an old-fashioned sense. For example, a small superficial epithelioma cured by the X-rays would not be regarded as malignant at all if we were ignorant of the terrible capacity for destruction so frequently shown in other cases anatomically similar. And what can be more remorseless than the course of some syphilitic tumours?

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* See *West Lond. Med. Jour.*, 1902, vol. vii., and *Lancet*.

The difficulty of distinguishing between syphilis and cancer is so common that it has to be faced every day.

No wonder, then, that, soon after Koch's discovery of the tubercle-bacillus, there commenced an earnest search for the micro-organism of cancer, and that an army of brilliant young men have thrown themselves into it with zeal and devotion—with what measure of success it is not in my power to say. I think an excellent case has been made out for the presence of minute bodies, either microzoa or bacteria, in cancer cells, and, remembering what such appearances mean in the histology of other diseases, I should have supposed that this was an observation of great weight and probable significance. But, encouraged by the failure of workers to fulfil all the conditions which Koch laid down as required for absolute proof of an organism being the cause of a disease, a school of critics has arisen who treat such observations with scant respect, a school which appears to have received considerable encouragement from the observations of Farmer, Walker, and Moore to the effect that nuclei of cancer cells sometimes divide and behave like those of germ cells.

But these observations cannot exclude the possibility of a bacterial origin of carcinoma, for they leave the peculiar incidence of primary carcinoma in the matter of place, and even of time, unexplained, while clinical facts, as I shall endeavour to show, are most strongly suggestive that living organisms introduced into the body from without, are the cause of cancer.

With regard to Professor Johannes Orth's dictum that "There is no necessity to assume a parasitic etiology in carcinoma," (*a*) this attitude on the part of pathology which has been struggling with might and main to find a parasite, is not unlike that of the inquisitive little girl who, being denied a secret she has striven to obtain, says, "Pooh, I don't need to hear it." Of course, only a great histologist can judge how pathological histology looks to her intimates, but to me, looking at her from a respectful distance, she seems to cut rather a sorry figure as regards the etiology of cancer, unless some of her votaries have really discovered a causative micro-organism.

The difficulty of proving to demonstration specific instances of infection is great even in acute diseases. Think of the eternal disputes between able observers as to the precise origin of typhoid epidemics. The furthest that is got in investigating them is usually no better than probability. With all the enormous opportunities for study in South Africa, it is still unsettled what was the relative share of water as compared with that of flies. If the typhoid bacillus were not as well known now as the Nelson column, quite a number of eminent medical men would be blaming smells, or, at least, emanations. The gentlemen who tore up all the drains every time a case of diphtheria or typhoid occurred, felt "no necessity to assume a parasitic etiology" of either. But with a slowly progressive, chronic malady like cancer, which on first commencing and for months afterwards cannot be recognised clinically, and is often not even seen during the first half-year of its existence by the doctor, it is very much more difficult to discover an immediate cause which can be proved.

Moreover, it cannot be denied that though cancer auto-infects with difficulty, otherwise early operations for cancer would not be so successful, it is terribly certain that it does auto-infect. If that were not true, late operations would not be such failures as they often are.

The same difficulties are found in tracing the precise source of the infection in most cases of tuberculosis, and for the same reason. And so it is even with actinomycosis. And thus it is that one case in which a strong presumption of infection is discovered outweighs a hundred cases in which nothing of the kind can be traced.

Before going further, let me deprecate the use of the term "pre-cancerous" as applied to some imaginary stage in which a sore or a tumour is assumed to be neither innocent nor malignant. It seems to me to complicate the difficulty we have in finding one boundary line by adding to it the further difficulty of looking for a second boundary line which has no existence. We need no such phrase to remind us that cancer is prone to attack old ulcerations, warts, and perhaps scars.

In considering what can be done to prevent cancer, let us bear in mind certain significant facts in connection with it. Most, if not all of them, I pointed out in the *Lancet* nearly four years ago. Some are well known, and will, I think, be denied by none.

1. All, or nearly all, carcinomata appear on the surface of the body, or of one of its cavities which communicate with the surface by some external orifice. A very large proportion attack the alimentary canal, many the face, head, hands, and legs, in fact, the parts which are least protected by clothes. If the clothed parts of the person were to be mapped out in square-inch areas, those particular square inches of the male body which are most frequently exposed for brief periods, namely the surface of the genitals, and, in the case of the female the breast, are the most frequent areas to be attacked with cancer.

They are also the parts most frequently handled.

(*a*) "Annals of Surgery," Vol. XL., p. 781.

Now surely these facts point to the origin of cancer in something introduced from without. It further supports the hypothesis of a cancer germ; for what influence introduced from without could possibly produce the phenomena of cancer with its power of auto-infection and of indefinite growth except a living organism.

Further, to quote from my own article in the *Lancet* of August 31st, 1901, vol. 2, pp. 584-586:—

"The commonest seats of primary carcinoma in the alimentary canal are obviously parts where food may lodge or adhere, *e.g.*, the lips, the margins and undersurface of the tongue, the tonsils, the gullet behind the larynx, and again where it is crossed by a bronchus, the lesser curvature of the stomach near to the pylorus, the pylorus itself, the ileo-cæcal region, the sigmoid flexure, the rectum, any part of the alimentary canal which has been the seat of chronic ulceration or of cicatricial contraction, and the lower portion of the large bowel in those curious cases of multiple polypi which tend to delay the passage of solid fæces, just as hillocks and trees check the downward course of snow on a hillside. All these facts seem to me to point to the probability of the cancer-germ being conveyed by food, but requiring time and rest to establish itself, while taking advantage of ulcerated and otherwise injured spots.

There are, it must be acknowledged, primary carcinomata arising in places which one would scarcely think of as accessible to food, *e.g.*, the laryngeal, the pancreatic, the hepatic, and above all the numerous uterine cancers. However, the larynx, the lungs, the pancreatic duct, and the bile ducts open directly or indirectly into the alimentary canal, and the uterus opens by way of a wide canal to the surface of the body. And it is obviously possible that primary cancerous infection may be conveyed *via* the blood-vessels or the lympathics, just as secondary is, no tumour forming at the seat of entry, and that it then rests and multiplies at some epithelium-lined cavity which it may reach, perishing in situations where there is no epithelium. Sir James Paget's view was that all primary growths were blood diseases, but the great success of early operations seems rather opposed to this. A secondary carcinoma arising in parts normally without epithelium implies that not only the cancer-germ, but the epithelium in which it lives and the growth of which it so greatly excites, has been conveyed from one part of the body to another. This assumes, as is customary, that all cells which resemble epithelium under the microscope are certainly epithelial in origin. But this is not absolutely certain. The microscope, assisted by modern methods, is a marvellous instrument, but the structure of things seen by it is in part made out by the imagination of the observer. Hence curious mistakes occur. For example, a primary cancer was pronounced by a first-class pathologist to be sarcoma, a secondary growth in the bones, of which the patient died a year afterwards, was declared by an equally good pathologist to be carcinoma.

While it is easy to explain the infection of a part of the alimentary tract by food, it is not easy to explain the infection of the mammary gland, unless it is through the blood. But the milk-ducts are obviously possible, indeed probable, channels for the conveyance of germs from the nipple to deeper parts. It seems to me that a not unlikely manner in which the nipple, or some eczematous spot on it, is infected is by the sufferer's fingers. It is true that the fingers are seldom dipped into food, and that only those of the lower classes often handle such things as cheese. Butter, however, comes frequently into contact with the fingers of nearly all women, and it is not considered sufficiently polluting to require that the hands shall be carefully washed afterwards. When considering the possibility of water being the cancer-carrying medium, I thought perhaps the nipple was infected by the linen, but linen and cotton undergo a treatment at the laundry calculated to kill any disease essence. Flannel, however, is treated more gently; still, even flannel, though not exposed to heat, is freely rubbed with soap.

With regard to the frequent occurrenee of cancer on the hands of workers in petroleum, on the scrotum of the chimney-sweep, the lip of the pipe-smoker, and in the lungs of the cobalt-miner, it is not very likely that the cancer or any other living organism would flourish in paraffin, in carbon, in smoke, or in ore which is a mixture of a metal with sulphur and arsenic. Such substances probably merely pre-dispose to cancer by preparing the soil, sometimes by causing a chronic eczema, a wart, or an ulcer.

The usual belief seems to be that non-operative treatment and the tissues of the body are powerless in the presence of cancer. The clinical evidence seems to me to point to a difference in degree rather than in kind between innocent and malignant tumours in this respect.

1. Malignant tumours sometimes retrograde and occasionally even disappear. This is most frequently noticed when the sufferer is being subjected to some special form of treatment, and consequently is being watched with special care.

2. Cancer does not loiter and live in the lymphatics on its way between a primary cancer and the nearest glands. Dr. Snow suggests that the cancer cause is destroyed by the lymph. (*West Lond. Med. Journ.*, Vol. VII., p. 117.)

3. With regard to treatment, cancer, especially when young and small, is sometimes seen to retrogress, at least temporarily, under the influence of the same measures as those often used successfully for the cure of tubercle, namely, iodide of potassium, X-rays, and even change to healthier and brighter surroundings. At least, the last-mentioned influence seems to delay recurrence. (D'Arcy Power.)

4. In my experience, Thiersh's skin grafts have appeared to possess a similar influence in preventing return after excision in the case of superficial cancers, to that which they have when the lesion is tubercle.

"If my remarks should lead anyone to avoid uncooked food, and if also it should prove in the end that articles of diet have nothing to do with the conveyance of cancer, let it be remembered that the danger of contracting other diseases, such as tubercle, typhoid, dysentery, diarrhœa, trichiniasis, tape-worm, and hydatids is already sufficient to justify such an attitude towards unsterilised foods. It is an attitude which a proper national system of instruction in hygiene should teach every school child to assume.

"The following rules for the prophylaxis of cancer might, therefore, be laid down safely, because even if they did not gain the end immediately desired they would attain others scarcely less valuable, just as the sons in the fable, though with all their digging they found no buried gold in the field bequeathed to them, yet gained health and rich crops.

"1. Chronic inflammations, suppurations, and especially ulcerations, should not be neglected or allowed to drift. Still better, commencing troubles of the kind should be treated promptly and not allowed to become chronic. With regard to ulcerations, especially of the alimentary canal, and with regard also to suppurations, especially of the breast, it is to be remembered that even the cicatrices left by their cure are said to be liable to become the seat of malignant infection. It is therefore doubly desirable to cure such ulcerations and suppurations in their earliest stage, so that little or no cicatricial tissue may remain, and in cases where the arguments for and against the removal, as opposed to the simple healing of an ulcer, are otherwise evenly balanced, the indication to remove a place especially liable to cancer, should prompt one to excision.

"2. Well-known sources of irritation of mucous membranes and of skin should be avoided—*e.g.*, smoking when any trace of soreness is discovered in the mouth, on the tongue, or on the lips, and the habitual use of strong condiments and spices. Workers in special trades, such as chimney-sweeping, should lose no time in having cutaneous rashes, warts and sores, promptly cured. Among milk products, cheese itself is an irritant to mucous membranes. Some syphilitics with a tendency to ulceration of the tongue notice that a fresh attack frequently follows eating cheese.

"3. A woman should allow nothing to come in contact with her nipples except smooth, clean linen, cotton, or silk, and the soap and warm water with which she washes herself. After being washed the nipples should be gently and thoroughly dried. She should not touch them with unwashed hands or fingers at all. During lactation, the nipple should be cleaned and gently dried after each act of suckling, and then protected with a dry and clean covering. The nipple should not be merely withdrawn from the infant's mouth and pushed back under the mother's clothes. If wool be worn it should be sterilised by heat.

"4. Whoever takes unsterilised flood should recognise that he does so at the risk of introducing into his system the germs of disease, and that among these disease essences, so to call them, may be that of carcinoma.

I have used the word "sterilised" because so few foods can be relied upon to be sterile unless they are artificially made so. But there are foods which may be reasonably trusted, even when raw, if prepared with care and cleanliness. For example, fruits and vegetables protected by rinds or shells, if perfectly fresh and sound, but not if in part decayed or blighted, also, perhaps, meats if examined by a careful and skilled person with a practical knowledge of animal pathology; although I do not know how the services of such an one could be available for any except the wealthy or the seriously ill, or in public institutions. The necessity of caution in these matters is shown by the fact that bacteria can occasionally be found in new-laid eggs.

Some of the vegetables and fruits which would be spoilt for the palate by being cooked should be carefully cleansed and in the case of tubers, quickly scalded superficially. Could anything be more careless or futile than the toilet to which grapes and strawberries are usually subjected? Think of the circumstances amid which both are grown, gathered, and packed for the market.

With regard to the process of sterilising food, it is not merely a question of cookery, it is also one of cleanliness on the part of all persons directly or indirectly associated with the preparation and serving of the food and of those who cleanse the utensils.

It is the demand for this which will be found most difficult to supply. The radically imperfect ideas of what is true cleanliness still existing among all classes may be seen any day in any hairdresser's shop, however fashionable.

The principal points to bear in mind are that nothing an be properly cleaned unless plenty of time, soap and warm water, as well as some elbow-grease are used, and that merely dipping dishes into a tub in which the other kind of grease is combined with dirty water is not sufficient even when followed up with a wipe from a dirty cloth,; but it is surprising and unfortunate that an excellent mimicry of cleanliness can be and is obtained in this way. Similarly the dirty coat-cuff which the barber while shaving rubbed on fifty noses yesterday leaves no mark on the fifty noses it may rub to-day, or at least none that will appear until it is too late to trace its origin, but it is none the less dangerous.

Is it then impossible to get a household into habits of true cleanliness? The daily experience of the best surgical hospitals shows that fair success can be obtained with unpromising materials. The first requirement is that the mistress should be truly clean herself. The second that her house should have a good hot water supply, and that she should not be parsimonious in soap, soda, towels, and cloths; the third that she should establish a proper system of washing, one in which basins shall be large, water shall be changed sufficiently, time and energy not grudged, and clean cloths supplied and used for wiping.

Another point is raised by what has gone just before. What if the poor cook herself is suffering from cancer? Three years ago (February 27th, 1902) Sir Alfred Cooper read an excellent paper on Inoperable Cancer, and in the debate on it I spoke as follows:—(*West London Medical Journal*, vol. vii.; also in brief notice in the *Lancet*):—"There is one aspect of the treatment of inoperable cancer to which I think attention is called practically never, and that is the protection of other people from the unfortunate sufferers from cancer. Everyone who accepts, as I suppose nearly all of us do, the hypothesis that cancer is probably due to some germ or other, either animal or vegetable, surely must realise that each case of advanced cancer, especially every case attended by discharge, must be a possible focus for spreading the disease among people who have hitherto been fortunate enough to escape. I do not think any of us give sufficient heed to that aspect of the question. I noticed in one of the medical journals the opinion expressed that cancer was spread by snails. I do not think the observer thought snails went about biting people who had cancer. But at all events it shows how readily we are to go altogether out of the way to find some causation for a disease when we have right before our eyes, constantly calling attention to itself, such a possible cause of the spread of cancer as the existence of these advanced inoperable cases, especially those of the throat and mouth which cause a discharge; as well as cases of ulceration of the breast (and other concealed parts) in unfortunate people who, even if educated, seem not to realise that their discharges may be mischievous to others." In the private consulting room, no less than in the hospital out-patient department, it is common to find patients with chronic ulcerations, and those who nurse them, so contemptuous of discharges, the sight of which would nauseate persons less familiarised, that they seem to go out of their way to put fingers and thumb especially the thumb, into the middle of each polluted dressing after removing it. And many are perfectly careless how and where they place the removed dressing.

They have generally behaved in this way for months or years and seen no harm come of it. But, as Huxley says, "Nature makes not the smallest allowance for ignorance," and the day of retributionco mes eventually, but, alas! in such a manner that it brings with it no readable lesson, and usually weighs more heavily on the innocent than on the guilty. Guilt is, of course, scarcely the word for lapses of whose danger the doers are absolutely unconscious.

We get diseases from one another, we give our diseases to one another, in childhood for the most part directly, in adult life oftener indirectly. (Hence the danger to health of crowded communities, of large schools, and of great cities.)

Safety lies in cleanliness, in the destruction of excreta and discharges, and in the avoidance of needless personal, physical intimacies. These truths make not only for health and long life, but also for morality and purity.

To sum up, for the prevention of cancer, we should look to—

(1) The sterilisation of food, including clean cookery and clean service.

(2) The destruction of discharges from ulcerations, especially if cancerous.

(3) The prompt excision of cancerous tumours or ulcers. Early removal of a cancer performed in a correct and thorough manner, not only gives the patient an excellent prospect of complete cure, but also removes a possible focus from which other people may become cancerous.

(4) The avoidance of physical familiarity except with those who are nearest and dearest to us.

(5) Abstinence from alcohol, tobacco, and from foods which leave waste products of which the kidneys, bowels and skin cannot easily and thoroughly get rid, and which thereby provoke and sustain the chronic

inflammations and ulcerations which so often pave the way for cancer. (*a*)

These rules tend not only to the prevention of cancer, but to the general preservation of health, and even to the promotion of morality.

THE

QUINIC ACID TREATMENT IN GOUT AND URIC ACID DIATHESIS.

By J. WEISS, M.D.,

Basle, Switzerland.

IN the year 1899 I suggested, on the strength of some physiological experiments I had made, that the employment of quinic acid in gout and uric acid diathesis in general should receive wider consideration. Since then numerous treatises for and against my theory have made their appearance, and many preparations been put on the market for which it was claimed that they possessed the power to relieve suffering humanity owing to their composition of quinic acid and some other previously known "gout" remedy (piperazine, urea, urotropine, &c., &c.). It should on the whole be superfluous to contradict so absurd a theory as that lithia, piperazine, and other bases are drugs inclined to in the least influence uric acid diathesis; but it is in medicine that obsolete ideas of this nature are not easily rooted out. Berthollet's dictum was that: "In a solution of acid and bases each acid is divided on to all the bases present according to the measure in which each base is present." Thus, the greater part of the urea must combine with the sodium which is present in large quantities; most of the lithia with the likewise preponderating hydrochloric acid. Despite these facts, lithia and piperazine continue to be used and no doubt improvement will be observed in a case occasionally—*post hoc, ergo propter hoc.*

Apart from the influence of a remedy on uric acid secretion, every consideration is due to the question whether this very point is really of such vital importance. It is not rare that uric acid secretion in the urine undergoes a change during an attack of gout, and, after all, we have before us only a symptom of a disorder whose origin lies in the nervous system. It is, more especially in France, a favoured method to attack the complaints in its place of origin by means of colchicum; but in view of the evil effects of this drug on the heart, I leave such treatment alone. Although the composition of the urine is unimportant for the determination of the gouty process as such, it will show us whether a drug has wrought any change in the organism. If, for instance, we observe a decrease in the uric acid secretion after administering quinic acid, and a simultaneous ample secretion of hippuric acid; if, further, we see that uric acid deposits in various parts of the body diminish, that the patient's general condition improves, we may conclude that the remedy administered has an influence on uric acid formation and secretion in the whole organism, acting either on the synthetic formation of uric acid or on the trophic nervous system. It has been alleged that quinic acid could only have an effect (if effect there were at all) in that benzoic acid, separating from the quinic acid, combines with glycocoll, thus forming the more soluble hippuric acid. An exceptionally smart firm offers, under the name of Urol, a combination of quinic acid and urea; according to the theory explained above the effect of one component, of course, cancels that of the other! Now, the greater portion of the uric acid in the human organism is not formed synthetically (as in birds and reptiles) but by oxydation. This, however can be no reason for us to abandon a remedy whose beneficial action is clearly proved. With no remedy can we trace an effect from reaction to reaction; neither with quinine in malaria, nor mercury in syphilis—to say nothing of serums.

As to observations, I should first of all mention that the task of determining quantities of uric and hippuric acid demands great skill and accuracy on the part of the investigator, as well as conscientiousness and reliability on the part of his "object." I consider it an impossibility to take as reliable the results obtained by some youthful experimentalists during a fortnight or even a month; for I have myself found with several hundreds of experiments that accuracy increases with the number of observations. It is frequently a question of very small quantities, where every milligramme is of importance as influencing the percentages. Then there are many processes which easily entail losses, and finally there is the necessity to obtain the urine as soon as possible after its release from the bladder; if 24 hours old it is useless, giving as it does, and as I have proved in my experiments, inaccurate results. Investigation as to quantity is of value only with a constant diet, under other conditions of diet it is useless to devote any time to the question of quantity. It really goes without saying that the composition of the urine is influenced by the nourishment received, but I mention it in consideration of various treatises which I have before me, and which have no claim whatever to any scientific value. With our clinical investigations the case is different, and by these the success of the quinic acid therapy has been undeniably established. It has been proved sufficiently, and beyond doubt, that quinic acid produces no undesirable secondary effects. I have personally taken doses up to 50 grammes, and have given similar doses to persons suffering from arterio-sclerosis and valvular disorders without ever noticing untoward effects. In its pure state it is unpleasant in taste and detrimental to the teeth, obliging us to use a salt. As the cheapest and most rational form I give the preference to urosine, the quinate of lithia—the lithia, as previously stated, always considered as a mere diuretic.

In view of the many utterances for and against quinic acid treatment (mostly based on one, sometimes two trials) I have recently subjected six persons to close observation, two of the number being arthritic patients. Whilst five showed a distinct decrease in uric acid secretion, this was not the case with the sixth, nor was there a noteworthy increase of uric acid secretion; with this patient the secretion was fairly ample also under normal conditions.

Experiment 1.—A. M., labourer, æt. 32, never been ill, apart from infantile complaints, and an attack of pneumonia when 16 years old.

Diet:—400 grammes meat, 200 g. bread, 50 g. butter, 90 g. sugar, 3 g. common salt, ½ litre water, 1 litre beer.

Quantity of urine.		Uric acid per day.	Hippuric acid per day.
2nd day	1400 g.	1.2634 g.	not ascertainabl
3rd ,,	1459 g.	1.3186 g.	,, ,,
4th ,,	1436 g.	0.9453 40 g. ac. quin.	0.8974 g.
5th ,,	1475 g.	0.6372 g.	0.9326 g.
6th ,,	1428 g.	0.9834 g.	0.2134 g.
2nd day	1422 g.	1.3024 g.	not ascertainable.
3rd ,,	1438 g.	1.2864 g.	,, ,,
4th ,,	1502 g.	1.0325 g. 30 tabs. uros. (15 g. lith quin)	0.6345 g.
5th ,,	1530 g.	0.8038 g.	0.7039 g.
6th ,,	1420 g.	1.1934 g.	0.1540 g.

Experiment 2.—T. E., labourer, æt. 45, never been ill, except with infantile complaints and gonorrhœa (when 20), the urine still showing threads at times. Same Diet as No. 1.

Quantity of urine.		Uric acid per day.	Hippuric acid per day.
2nd day	1589 g.	0.8432 g.	not ascertainable.
3rd ,,	1536 g.	0.9046 g.	,, ,,

(*a*) This included rule forbids that excess of meat-eating, &c., to which the late Sir Mitchell Banks, Dr J Haig, and others have not unreasonably given a place in the etiology of cancer.

	Quantity of urine.	Uric acid per day.		Hippuric acid per day.
4th day	1578 g.	0.6845 g.	40 g. ac. quin.	0.7345 g.
5th „	1530 g.	0.3536 g.		0.9042 g.
6th „	1564 g.	0.5279 g.		0.1035 g.

2nd day	1578 g.	0.8734 g.		not ascertainable.
3rd „	1563 g.	0.8523 g.		„ „
4th „	1625 g.	0.7524 g.	30 tabs. uros.	0.6234 g.
5th „	1705 g.	0.5368 g.		0.8043 g.
6th „	1608 g.	0.6734 g.		0.0978 g.

I conducted these two experiments in two parts at eight days interval, the first with pure quinic acid, the second with urosine. Both gave the expected results. In the following experiments I employed only urosine tablets à 7½ grains lith. quin. Diet same as in Experiments 1 and 2.

Experiment 3.—E. K., book-keeper, suffers from pulm. emphysema.

	Urine.	Uric acid per day.		Hippuric acid per day.
2nd day	1480 g.	0.9123 g.		not ascertainable.
3rd „	1538 g.	0.9546 g.		„ „
4th „	1620 g.	0.6734 g.	30 tabs.	0.5203 g.
5th „	1705 g.	0.4258 g.		0.7840 g.
6th „	1605 g.	0.7034 g.		0.2036 g.

Experiment 4.—S. B., commercial man, æt. 54, arthritis urica since 35th year, showing itself in periodical swellings of one or both phalangeal joints every 1—3rd year. Father said to have had gout.

	Urine.	Uric acid per day.		Hippuric acid per day.
2nd day	1506 g.	0.8734 g.		0.0432 g.
3rd „	1532 g.	0.8234 g.		0.0487 g.
4th „	1605 g.	0.7964 g.	30 tabs.	0.4326 g.
5th „	1628 g.	0.5034 g.		0.4873 g.
6th „	1593 g.	0.6845 g.		0.0985 g.

Experiment 5.—L. M., commercial man, æt. 47, arthritis urica since 42nd year. Four attacks in five years.

	Urine.	Uric acid per day.		Hippuric acid per day.
2nd day	1623 g.	1.2456 g.		0.0056 g.
3rd „	1642 g.	1.1978 g.		0.0052 g.
4th „	1648 g.	1.0365 g.	30 tabs.	0.1135 g.
5th „	1705 g.	0.7536 g.		0.4263 g.
6th „	1613 g.	0.9645 g.		0.2305 g.

Experiment 6.—R. B., clerk, æt. 30, no illness except infantile complaints recorded.

	Urine.	Uric acid per day.		Hippuric acid per day.
2nd day	1532 g.	1.2056 g.		0.8756 g.
3rd „	1551 g.	1.2134 g.		0.8943 g.
4th „	1526 g.	1.0024 g.	30 tabs.	0.9046 g.
5th „	1684 g.	0.9586 g.		0.8927 g.
6th „	1606 g.	1.0345 g.		0.9034 g.

This last case was all the more interesting as Hupfer (in a by-the-way very poor treatise) describes similar results from the treatment of his own case, and considers himself justified to thereupon condemn the quinic acid therapy from a scientific point of view.

In order to establish clinically whether arthritis urica is influenced through quinic acid, *i.e.*, urosine, I experimented on a number of people, some of whom suffered from chronic, others from periodically, at fairly equal intervals, recurring attacks of arthritis urica.

Case 1.—A. T., late officer in the army, æt. 58, obese, gouty deposits in several finger joints. Numerous gouty attacks since 43rd year, consisting in painful swelling of the big toe. He took, in 1900, at the commencement of one of these attacks, 10 urosine tablets (equal to 5 grm. with. quin.), whereupon swelling and pain decreased considerably. The same dose was again administered after one week and then modified to eight and six tablets daily in the course of a month. In the following spring the patient without experiencing his old complaint, took six tablets for one month; likewise in the year 1902. During all this time there were no attacks, whilst patient had had to face at least two attacks annually previous to treatment.

Case 2.—E. R., butcher, æt. 45, had, in 1898, a typical gout attack in right metatarso-phalangeal joint, which recurred every year, lasting from seven to fourteen days. In May, 1900, patient began taking six tablets urosine daily for one month, and has repeated this every year since. There have been no further attacks. In the summer of 1901 he felt a slight pain in the affected joint, whereupon he took ten tablets daily for a week, with the result that the pain disappeared completely.

Case 3.—P. S., commercial man, æt. 50, for ten years troubled with arthritis urica. Numerous tophi in finger joints, gout attack lasting from fourteen to forty days every summer. In the year 1901 he commenced an urosine treatment, taking ten tablets daily, as soon as pains in the right big toe appeared. After a fortnight of this treatment he was at least no longer quite incapable of moving about. In a further fortnight the disturbing symptoms had ceased; nevertheless, the dose of ten tablets daily was maintained for another fortnight, then decreased to eight tablets during fourteen days, and subsequently to six during a like period. In the following spring he took ten tablets daily for a fortnight, eight daily during the next, and six during a third period of fourteen days. There was no attack, and there has been none since, as patient has repeated the treatment every year.

I have mentioned a few typical cases; similar ones have been observed by others. I have found that a month's urosine treatment in the spring (10, 8, and 6 tablets, as in Case 3) is able to suppress those troublesome gout attacks generally experienced in the summer, without producing untoward secondary effects. Such food as consists wholly or partly of pancreas, &c., should be avoided; otherwise restrictions are unnecessary. The tablets are best taken dissolved in water, at meals.

I am able, on the strength of my experience, to recommend the urosine treatment, and here repeat what I said at the Medical Congress at Wiesbaden in 1900: "In urosine, the quinate of lithia, we possess a remedy which, in the treatment of uric acid diathesis, ranks as high as the salts of salicylic acid in articular rheumatism and the quinine salts in malaria."

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THE
TREATMENT OF INSANITY
BY THE
ADMINISTRATION OF SHEEP'S THYROID SUBSTANCE.

By RICHARD R. LEEPER, F.R.C.S.I.

Medical Superintendent, St. Patrick's Hospital, Dublin.

ONE finds that the administration of the ordinary drugs used in the treatment of physical illnesses gives very vague and often completely negative results when exhibited in the medical treatment of the insane.

Sedatives excepted, the good results obtained by drugs administered solely for the purpose of favourably influencing its psychical disturbances associated with mental diseases have proved wanting. Even in such a sharply defined disease as locomotor ataxy and the general paralysis of the insane, where a specific cause is definitely ascertainable, the drug treatment ordinarily indicated, and used in syphilitic disease is found to give no definite results; indeed, the early inunctions of mercury and the administrations of iodide of potash would appear from my own experience to actually accelerate the downward course of those suffering from a specifically caused degeneration of the cortex or cord.

Patients sent to mental hospitals for their treatment are complex puzzles, as the symptoms of disease must ever puzzle us when unexplained by a clear conception of normal function; and when treatment is based upon a vague, nebulous, and often a merely scientifically imaginative pathology, treatment must necessarily at present be empirical or open to some experimental possibilities when pathology leaves us so far unenlightened. Brain symptoms we presume are due in some cases to hæmic or intestinally absorbed toxins, inflammatory conditions, or bacteriological organisms or exudates around the nervous centres derived from one or all of the disordered blood, lymphatic or glandular symptoms. One must necessarily be at a loss to select a remedy which will favourably influence a disease the etiology of which is so confusing, and often merely conjectural, and the pathological chemistry of its varied forms must, as yet, be regarded as inseparably connected in uncertainty with the present state of our knowledge as regards the physiological chemistry and changes of tissue associated with normal and healthy life.

The clinical picture of stupor, mania, or melancholia is clear enough. Would that we could as clearly recognise the pathological conditions which underlie these states, then doubtless many remedial courses which are at present lying at our hands would be ordinarily employed, but which now lie neglected owing to want of knowledge as to their uses and applicability. Small are the crumbs and fragments of definite knowledge which are available to guide us in our search for a sound and more precise therapeutical means of grappling with the problems of psychiatry.

It appears to me that the treatment of insanity must be based upon the principle of broadest conception, so that treatment must be directed to so altering metabolic processes as to stimulate into increased vitality and functional life the various organs temporarily aberrated by the onset of insanity; or producing that disease by their primary disturbances. We must look, therefore, to general systemic remedies if we wish to influence or markedly alter the course of the mass of symptoms, mental and physical, which we are called upon to treat. We must treat the patient as a whole, not confining our drug exhibitions to the alleviation of symptoms produced as we may conjecture by altered blood pressure, anæmia, or a cerebral intoxication produced by the absorbed auto-intoxicants of degenerating nervous tissue, or that carried from other sources within the body, and producing the phenomena of mental disease.

Surgery has been disappointing in its results, and the trephining of the skull, as a remedial remedy for mental conditions, unassociated with traumatisms, or localised disease, is in the present state of our knowledge an unwarrantable proceeding.

Viewing the treatment of insanity from these standpoints of present-day knowledge, I some years ago sought in organotherapy, a remedy potent and physiological, and with the then known results of the exhibition of gland substances, I commenced to use the sheep's thyroid gland as a means of favourably affecting or modifying the condition of the insane. My first case was one of chronic mania associated with ill-defined myxœdematous symptoms. This case rapidly improved, and left the hospital completely recovered.

I then and subsequently used the sheep's gland in tabloid form in cases of stupor, mania, and melancholia.

I have in all treated twenty-two patients with thyroid extract administered in the form of 5 gr. tabloids manufactured by Burroughs and Wellcome. The dose is gradually increased from 10 grs. daily to as much as 60 grs. in some severe and otherwise intractable cases, and continued until reaction occurs. In all cases the patients have been confined to bed during treatment, and have been most carefully nursed and constant observation of pulse and temperature recorded. The treatment has been discontinued when a noticeable rise of temperature or increased pulse rate has been produced. In no case have I had any accident or reason to suspect that the patient was unfavourably influenced by the treatment. In one case which I considered from the first a rather unfavourable one for treatment, a severe gastric crisis seemed to have resulted from the administration of the substance. This was the case of a girl with a neurotic inheritance who was partially demented and suffered from a large goitre.

The treatment entirely removed the large goitre, but failed to produce any change in the mental state.

Of twenty-two cases treated, suffering from various forms of mental trouble, seven were males and fifteen females.

Three of the men completely recovered, and two of these three patients were homicidal to a marked degree.

I have treated three patients in all, suffering from homicidal impulses with thyroid extract. In all of these three cases a marked change took place subsequent to the thyroid treatment, and the morbid impulses seemed to be lost. I cannot say if this observation may be regarded as anything more than a coincidence, but I commend it to the consideration of those who have a better opportunity of further investigating the results of thyroid treatment with this difficult class of patient. It is interesting to note that it has been suggested by Lugaro to partially extirpate the thyroid in cases of moral insanity; an excessive secretion of thyroid being regarded as the cause of excessive amativeness, thieving and other mental warps of degeneracy.

Should the exhibition of sheep's thyroid prove favourable in cases suffering from homicidal impulses, it may be conjectured that the human secretion and that of herbivorous animals may act in different ways and affect mental states in different degrees. The carnivora seem rather more affected by extirpation of the thyroid than herbivorous animals, and much good work in the direction of ascertaining the comparative amount of iodo-thyroin found in the secretions of different animals and a comparative analysis of the secretion in herbivorous and carnivorous animals is much needed so as to allow of the selection of that secretion most potent medicinally.

Of the twenty-two patients treated by me with sheep's thyroid, twelve recovered and were discharged from the hospital, and have not since, so far as I can ascertain, been treated with one exception elsewhere or required re-admission here.

Some of the cases had been for some years insane, and had been transferred here from other asylums and were regarded as incurable by their relatives.

My experience of the clinical symptoms produced by the administration of thyroid substance coincides generally with that observed by Bruce. It seems to act primarily by increasing the cardiac action and pulse rate, with lowered blood pressure. In but two or three cases did a rise of temperature first appear as a reaction to the treatment, and even after the use of the substance in large doses for some weeks, the temperature never rose beyond 102°. I have in all cases ceased to administer the substance upon the advent of pulse or temperature reaction.

All of my cases lost weight rapidly whilst under treatment, but more than regained (often by some stone), this loss upon the cessation of the gland tabloids, thus indicating that the ultimate cellular metabolism of their bodies was stimulated by the effect of thyroid feeding. From my observations of the effect of thyroid I believe it to be imperative upon us to give otherwise ill-doing cases the benefit of a course of treatment by this means. I believe it to exercise a marked and noticeable effect upon the ideational and intellectual faculties.

The result obtained in one of the cases otherwise unfavourably affected by the treatment was most noticeable.

A. B. was a young married woman possessed of a very insane family history. She was always a neurotic and rather eccentric woman. She married a drunken and dissipated husband, who robbed her and deserted her, leaving her with three small children. Her insanity dated from this period, and upon her admission she was apparently semi-demented, incoherent, and stuperose. Could not at times be induced to speak or take any interest in her surroundings.

She was given large doses of thyroid and the substance was increased until she was taking 30 grs. a day, when a decided rise of temperature and increased pulse-rate occurred.

She became more rational, but exhibited great anxiety, and would ask me, "Don't let him kill me," "Don't let him hurt the children," which she had never before asked about or taken any interest in.

Evidently the mental distress had been recalled, and the state of anxiety restored which immediately preceded, and was the undoubted exciting cause of her attack of insanity.

With the cessation of the thyroid feeding and the physical symptoms produced thereby the anxiety disappeared, and the patient has again relapsed into her demented state.

Suicidal impulses have been recalled as result of thyroid feeding in persons who were suicidal and had become partially demented; and this was noticeable in one of my cases who had attempted suicide by cutting her throat before admission here. She eventually completely recovered, and was discharged some years ago, and has since remained well.

Thus morbid as well as normal mentalisation can be stimulated by this extraordinary gland secretion. I have no experience to warrant my drawing conclusions as regards the value of organotherapy by the secretions and substances of other organs, such as the suprarenal, &c. I was much gratified to find that the distinguished neurologist's (Dr. Marie) experience of thyroid coincides with my own. He told me he derived no good results from the administration of other gland substances. It occurs to me that the administration of parathyroid substance (if a trustworthy preparation of this portion of the thyroid area is obtainable) would be likely to give marked results in connection with the nervous system.

In the cases of dementia præcox, or adolescent insanity with insane family histories, treated by thyroid by me, I have had some strange results. In two young men so treated they appeared to apparently recover, became rational, bright, and sensible for short periods, and again relapsed and are still insane.

These cases would appear to suffer from a congenital brain instability which breaks down at the developmental period of adolescence, can be forced into an apparently normal condition for a brief period as the result of the stimulative action produced by thyroid feeding.

I have treated these cases by a second course of the substance, but with no appreciable result, the nerve recuperative power being exhausted; and incapable of re-stimulation into normal activity.

In the sheep's thyroid we undoubtedly possess a substance capable in selected cases of modifying most and curing many forms of mental disease. Whether the administration of herbivorously derived thyroid supplies some want in the deficient or diseased human secretion, or whether mere excess of iodothyroin or other substance of the gland, no matter where derived, is of benefit to insane states remains for future investigators to decide.

The Out-Patient Departments.

THE ROYAL BERKSHIRE HOSPITAL.

Cases under the care of R. PHILIP BROOKS, F.R.C.S.,
Ophthalmic Surgeon to the Hospital.

CASE I.—*Congenital Aniridia of both Eyes with Stellar Cataracts.*—Ellen L., æt. 19, has always had bad sight.

Examination.—Both corneæ clear, but no iris visible in either eye until light is focussed obliquely into the angle of the anterior chamber, when a narrow band of iris tissue is seen.

By direct examination with the mirror of the ophthalmoscope a large star-shaped opacity can be seen near the posterior capsule of the lens. The peripheral portion of the lens is quite clear. Its margin can be well seen and beyond this a narrow space representing the suspensory ligament, but no ciliary processes are visible.

By indirect examination with the ophthalmoscope the optic discs can be fairly seen and appear normal.

The condition of both eyes is similar, the cataract being rather larger in the left.

Vision.—R. eye=3–60 and with sph.$_{36}$3·5D=6–24.
L. eye=3–60 and with sph. + 3D=6–
With the above glasses the patient could read J2 of the small type fairly well, and these glasses were therefore ordered for constant use. There was no history of any similar condition in the family.

Case. II—*Hypopyon Ulcer with Lachrymal Obstruction.*—Ann J., æt. 54, complained that the right eye had been bad for three weeks.

Examination.—The centre of the cornea is occupied by a deep infiltrated ulcer covering the whole of the pupil. The iris appears dull and sluggish, and the lower segment of the anterior chamber is filled with a hypopyon. There is marked ciliary infection and much conjunctival discharge. The edges of the lids are reddened, the lower lid being excoriated and somewhat everted. Pressure over the position of the lachrymal sac causes a regurgitation of muco-pus from the lower punctum.

Treatment.—After several instillations of cocaine and the conjunctival sac having been washed out with a solution of hydrarg. biniodide (1–10,000) the point of a Weber's knife was entered through the lower punctum and the canaliculus divided. Couper's probes Nos. 3 and 5 were passed through the nasal duct.

The lids were then kept apart by a speculum and the eyeball held by fixation forceps, while the galvano-cautery was applied to the edges and floor of the ulcer. Atropine ointment was then applied and the eye dressed with a boric acid fomentation and a light pressure bandage.

Remarks.—The frequent association of hypopyon ulcer with lachrymal obstruction is of great importance in treatment. The absence of regurgitation on pressure over the lachrymal sac does not disprove obstruction. Therefore, whenever the hypopyon relapses after treatment, the nasal duct should be probed or at least syringed through to demonstrate its patency, otherwise our best efforts may be thwarted by a continuous reinfection of the ulcer from the lachrymal passages.

Transactions of Societies.

THERAPEUTICAL SOCIETY.

Sir Lauder Brunton, Bart., M.D., F.R.C.P., in the Chair.

At the last meeting of this society, Dr. G. Herschell read a paper on the

APPLICATION OF DRUGS TO THE INTERIOR OF THE STOMACH BY MEANS OF SPRAYS OR NEBULÆ.

He said that this mode of administering drugs was useful, as it gave a certainty of the drug reaching the affected part, though only a small quantity of a strong solution was used, and thus prevented any poisonous effect. One half-ounce of spray would cover the interior of the stomach as effectually as 10 oz. of a solution. The spray is used either to disinfect the stomach, to act as an astringent or styptic, or thirdly to relieve the pain of cancerous or other ulcers. It is very useful in erosions, chronic gastric catarrh, and hyper-secretion. The best apparatus is Einhorn's, made only by Tierman of New York, consisting of a spray producer and a long soft rubber tube. The solutions used are silver nitrate 1 in 500 or in 1,000, 1 in 1,250 of cocaine, 1 in 1,000 of either hydrochloric acid or of adrenalin.

The drug must be administered when the stomach is quite empty, and has been washed out and the water removed by an aspirator. Thus the distance from the teeth to the stomach is ascertained, and marked on the soft tube by a ring of rubber, the warm tube is then passed down the œsophagus to this point, and the spraying commenced by pressing the ball for three or four minutes, while the tube is gradually pushed on for 3 centimetres.

Silver nitrate is especially useful in erosions, also in chronic gastritis, and in hyperchloridic acid secretion. In gastralgia cocaine gives great relief immediately, even in small quantity. In hæmorrhage adrenalin in spray stops the bleeding, but the tube must not be passed more than one inch into the stomach.

Nebulæ are atomised oily or viscid liquids finer than spray, by being broken up against the walls of the instrument, by forcing the liquid by a pump or bellows through a globe nebuliser and down a double soft rubber tube into the stomach. The double tube prevents over-distension. The nebuliser is then removed, and all the vapour allowed to escape. The usual solution employed consists of oil of cinnamon ½dr., menthol 1dr., and paroleine 1oz. Cinnamon oil is one of the most powerful disinfectants, and menthol is used for its soothing qualities. This process is chiefly used for thoroughly disinfecting the stomach in cases of motor insufficiency which cannot be accomplished by drugs give by the mouth.

Dr. Bryant not being able to attend the meeting, Dr. Herbert French read the paper on

ALGINOID IRON

for him. It is claimed for this drug that it has two advantages over other compounds of iron; first, it does not derange digestion; second, it does not cause constipation. Alginic acid is a nitrogenous acid obtained from seaweeds, which forms an insoluble salt with iron, by decomposing ferric chloride with sodium alginate. It is a brown tasteless powder not changed by acids, or the gastric juice, but decomposed by alkalies. It contains 10 per cent of iron. It is best given in powder or cachets, dose 2 to 15 grains. It is particularly useful in cases of chlorosis with vomiting and pain in the stomach, as it acts as a sedative instead of irritating it, checking the vomiting and not causing constipation. It may be conjoined with arsenious acid. It is especially useful in anæmia arising from the hæmatemesis of gastric ulcer, as its sedative action relieves the pain, and checks the vomiting, and the general aspect of the patient improves, and the hæmoglobin of the blood is increased. In one case of chlorosis the hæmoglobin increased from 40 per cent. to 72 per cents. in six weeks, after taking 10 grains of alginate of iron three times a day.

The advantages of this preparation are;:—

1. It is tasteless but contains 10.97 per cent. of iron.
2. It has no astringent effect and does not cause constipation, but is slightly laxative.
3. It is not changed in the stomach, and may be given even during vomiting, as, like salts of bismuth, it acts as a sedative.
4. It is readily borne by patients who can take no other form of iron.

CENTRAL MIDWIVES BOARD.

Meeting held June 29th.

Dr. Champneys, President, in the Chair.

A letter was read by the secretary from the Committee of the Queen Victoria Jubilee Institute for Nurses, protesting against the recent decision of the Board to hold four examinations in the year instead of three, and asking the Board to reconsider its decision.

As several letters of this kind had been received, it was agreed to hold a conference on the subject on June 29th, and to invite the various bodies to come or send delegates.

The vexed question of fees to medical men called in in times of difficulty and danger, and who should pay those fees, was then discussed. The doctors of Southend had unanimously arranged not to take less than two guineas, but the fact would certainly deter people from calling in a midwife if, along with her 12s. 6d. there was a possibility of another two guineas to be paid. Dr. A. W. Aldrich, of Leyton, in a letter (quoted) complained that he had been offered half a guinea when called in in an emergency by the midwife.

It was agreed to return answer that no fee had been fixed by the Board, Miss Paget adding that 10s. 6d.

was a large sum to come out of the nurse's own pocket.

With regard to the examination in October, Dr. Robert Boxall and Dr. Alexander Stokes were appointed as two examiners, and Dr. G. E. Herman and Sir William Sinclair as visitors.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, July 1st, 1905.

MALPRAXIS.

Dr. Le Fort, a well-known specialist in urinary affections and particularly in the treatment of stricture by electrolysis, in which he has been particularly successful, came to grief in two cases some time ago, and for which he had to appear before the police court last week. The first case was that of stricture of the œsophagus. While passing the electric bougie, a considerable portion became detached and lodged in the stomach. As the patient was too weak to attempt gastrotomy, nothing was said about it, and finally the man succumbed to the primary affection. This accident was not imputed to the surgeon, however, by the prosecution. The other case was stricture of the urethra, and from some fault in the instrument, as in the first case, several inches became detached and entered the bladder. For some strange reason the operator concealed the accident not only from the patient, but also from his relatives, and several months afterwards the patient succumbed to chronic cystitis. Nothing probably would have been known about either case, were it not that Dr. Le Fort had for some reason dismissed his secretary, who, in order to be avenged of what he considered an undue treatment by his employer, retaliated by disclosing the secrets.

The defendant brought forward several of the best medical authorities to testify that, after all, the foreign bodies did not accelerate death, and which the court allowed; but they blamed him for concealing the accidents, and imposed a penalty of two pounds.

A QUESTION OF SURVIVANCE.

An enterprising confrere in search of notoriety attended the execution of a criminal last week, and arranged with the executioner that as soon as the head fell into the basket he (the doctor) would take it in his hands and shout into the ear the name of the murderer to see if he would respond by some sign. The experiment was gone through as stated and the doctor affirms that the head opened its eyes twice when his name was pronounced. Very little credence is given to the doctor's story, and in any case such experiments are of very little scientific value.

The above reminds us of a similar experiment tried in the days of the Empire—we mean that of the celebrated La Pommerais. La Pommerais was a doctor practising in Paris, and for some reason or other became a criminal. He insured the life of a woman to whom he was attached and then poisoned her. He was tried and condemned to the guillotine. The night before his execution he was visited by a friend and confrere who asked him in the interest of science if he would open his eyes if he heard his name called out after decollation. He promised to do so, but when his confrere held the head in his hands and called him by name there was no response The eyes remained closed.

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, July 1st, 1905.

At the meeting of the Medical Society the discussion on

CEREBRO-SPINAL MENINGITIS

(called for some reason in the English papers "spotted fever") was continued.

Hr. A. Baginsky said he had had no increase of tuberculous meningitis lately in his department. It was always rather more frequent in the earlier part of the year, and became less frequent later on. The differential diagnosis between tuberculosis and sporadic meningitis was not so difficult in general. In the acute form the disease began more suddenly. The sensorium was deeply affected only in the very acute cases in those running a slower course, it was always free to some extent, whilst in tuberculous meningitis the sensorium was early attacked and at the most lucid moments were observed. In tuberculous meningitis the temperature was only moderately high, but very high in the other form. The stiffness of the neck in the sporadic form even when it was slow in its progress was much more pronounced through the whole illness than in the tuberculous disease. In the latter disease the spinal fluid was clear, and most delicate flocculi were deposited on standing, in the sporadic disease it was clouded—an *obiter media* might under some circumstances cause a mistake in diagnosis. There was also an influenza form that could only be distinguished from cerebro-spinal meningitis with difficulty. He saw a case which even the autopsy did not render clear. He had only found the meningococcus in small numbers. As regarded treatment, we had to confess our helplessness in regard to it.

Hr. Henke laid stress on the fact of the difficulty of deciding even *post mortem* as to the nature of the disease, whether it was the epidemic form or not. he had previously found both the meningococcus and the pneumococcus. He had produced meningitis experimentally with both. For a decision on the question, the absence of any primary disease such as otitis, pneumonia, or angina was of importance.

Hr. Friedberg described a case of hydrocephalus that was punctured and recurred repeatedly. The child never had fever, but diplococci were found in the fluid removed. These were cultivated by Wassermann and declared by him to be Jäger-Weichselbaum meningococci.

Hr. Grawitz also spoke of the difficulty of early diagnosis when it was most important. Meningitis was not a disease of childhood, by preference it attacked people in early manhood, especially soldiers.

Hr. Westenhœffer said that the most important result of his investigations was that infection did not take place through the ~~cribriform bone~~, but through the posterior wall of the fauces. Angina had often been noticed among those living in Silesia.

Hr. Kirchner said that in Upper Silesia 2,406 cases had been reported, with 1,491 deaths. The death rate, 63 per cent., had now become higher, as many of the cases running a chronic course had since died.

To combat the disease effectively it was necessary to report even suspicious cases, and not to wait until the diagnosis was clear in every case. Adults had only a slight receptivity as regarded the disease, but it could be heightened by certain injurious conditions such as military service.

At the Surgical Congress Hr. Friedheim reported on the permanent results of operation for Basedow's or Graves' Disease. Twenty cases were operated on. Operation was the only known means of permanently curing the disease, and the dangers of it were not great. All the cases operated on were bad ones. One patient died of tuberculosis four years after the operation, fourteen were permanently cured, five of them had needed no medical aid for from nine and a half to eleven years. Three were described as much improved. One death was to be deplored; it occurred in the case of a girl æt. 23, for whom first the right, and six weeks later the left, struma was removed, so that only a small isthmus remained. Tetanus came on and proved fatal on the tenth day. The first successful treatment by operation was reported in 1884. The report was received with doubt as the goitre was everywhere looked upon as only an individual symptom of the disease. Now it was known that the hypersecretion of the thyroid was in casual relationship to the disease, and many surgeons in consequence of this had carried out the operation. In order to avoid serious consequences, only a part of the gland should be removed, but as to how much should be taken away, there was no agreement in opinions, as no one knew how great a quantity of poison there must be to lead up to the disease.

Many surgeons operated tentatively, removing only comparatively small portions of the gland at each of several successive operations. Perhaps in this way a later operation might lead to a cure in the three cases reported as much improved.

Rehn had made a collective investigation as to results, and this gave 50 per cent. of complete successes, with a mortality of 20·1 per cent. The speaker's own material gave 70 per cent. of cures and a mortality of 5 per cent., and Kocher, Krönlein *v.* Mikulicz and König had had equally good results.

Hr. Kocher of Berne could fully confirm the statement made. The result of surgical procedure gave the proof as to the nature of the disease. He said that the best results were obtained in the recent cases. Fatalities should be debited to late operations.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 1st, 1905.

VAGINAL ATROPHY.

AT the Gesellschaft der Aerzte, Peham exhibited a patient, æt. 40, with partial obliteration of the genitals. The woman had never menstruated, nor been troubled with molimena menstrualia. The mammæ were well developed, mons veneris normal amount of hair, labium, clitoris and nymphæ fully developed. The site of the vagina is covered by an irregular fold of the hymen which guides the finger into the urethra and thence easily into the bladder, through which she has had sexual intercourse since her marriage twenty years ago. From her own description libido and sexual sensation in coitus appears to have been normal. From this enormous distension of the urethra incontinence of urine caused her to seek medical advice last year. The ordinary remedies failing, an examination revealed the above abnormal condition.

The internal organs of generation could not be exactly described in the present condition, but external examination revealed a small firm body on each side, about the size of a mussel, which were assumed to be ovaries.

PSEUDO-ARTHROSIS.

Lorenz made another attack on Mosetig for his ill-advised criticism of Lorenz's treatment of coxitis and the production of pseudo-arthrosis after the operation. As a proof of what he believed, Lorenz brought forward fifteen cases where ankylosis had occurred after operations, and which he had treated without surgical interference, and produced functional movement. He further showed a series of cases of coxitis at present under treatment in whom he also hoped to obtain pseudo-articular movement. He admitted that operative treatment was an ultima ratio, and that extensions and bed fixtures as well as portable extensions and fixation apparati should all be banished from the mind as iniquitous agents in the treatment of joint diseases, producing irreparable atrophy of the affected limbs. He characterised them as the worst of crutches concealed beneath the clothes. During the last ten years he had practised functional and physiological methods in the conservative treatment of joints and never used extension and fixation as usually practised. Practice had taught him that the fixation of the hip-joint is relatively easy and painless, requiring a very short time for the functional and physiological treatment. Mosetig in reply, recounted the various indications, course, and symptoms of coxitis. At the beginning of the treatment he admitted that it was more of an expectant orthopædic hygienic nature than of heroic form, but when pus formed arthro-oncotomy was a necessity in all severe conditions. Where spontaneous luxation and extra capsular abscesses formed associated with fever and other complications, he considered resection unavoidable; even in some cases where the abscesses produced fistulæ in the healing process resection was also indicated. Eiselberg thought that this wordy warfare was based upon fallacious premises, as Mosetig was reasoning from the worst of cases, while Lorenz was forming his method of treatment on mild ones.

CONGENITAL SYPHILIS.

Hochsinger showed a man, æt. 21, whose history pointed to congenital syphilis. When a child he seems to have been treated for the disease, and at a late period suffered from hepatic and cerebral symptoms of the disease. During the exhibition of these para- and meta-syphilitic affections he suffered from paroxysma hæmoglobinuria which would occur when he was five years of age. When eleven he suffered from ocular paralysis and other cerebral symptoms. At thirteen enuresis, aortic trouble, and neurasthenia set in; at seventeen infantilismus and the first symptoms of the present condition tabes dorsalis were observed with changes in the joints of the little fingers. The Röntgen rays confirmed the infantile anomaly of want of union between the bones and epiphysis of the phalanges. The present state shows that the bones are unchanged with a great thickening of the synovial membrane. This synovitis chronica hypertrophicans is also present in the joints of the small bones. Teleky asked if the mother of this young man had been treated for syphilis which he considered important in the transmission of syphilis to children, as he felt some scepticism in many of these cases. Hochsinger in reply, feared that he could not give him such information, neither could he elicit any proof that would confirm the presence of such a disease in the mother.

Operating Theatres.

ROYAL FREE HOSPITAL.

OPERATION FOR ACUTE INTESTINAL OBSTRUCTION DUE TO VOLVULUS OF THE SMALL INTESTINE.—**MR. WILLMOTT EVANS** operated on a woman, æt. 26, who had been admitted for acute abdominal pain and vomiting of thirty-six hours' duration. Two years previously, she had been operated on at another hospital for an ovarian cyst. There was a well-marked history of gastric ulcer with hæmatemesis. The day before admission she woke up with intense abdominal pain, vomiting soon commenced, and recurred every few minutes; she was unable to keep down any food. The constipation had been present for two days. The pain and sickness steadily grew worse, and on the evening of the next day she was brought to the hospital. On examination the abdomen was distended, painful, and tender, and hardly moved at all on respiration. The scar of the former operation was seen in the middle line below the umbilicus. The patient was much collapsed. It was obvious that an acute intestinal obstruction was present, and it was decided to operate at once. As it was considered that the obstruction might be due to adhesions in connection with the former operation, the abdomen was opened not through the scar but about half an inch to the left of the middle line. When the peritoneum was divided, collapsed bowel was seen, and on examination with the hand it was found that distended small intestine was adherent to nearly the whole length of the scar. On tracing the distended bowel downwards, it was found that about two inches below the adherent bowel the small intestine was bent sharply on itself, the bowel immediately below being collapsed. The adherent intestine was dissected carefully from the abdominal wall, and as soon as this was done the previously collapsed bowel became distended. Five stitches were placed in the wall of the bowel where the adhesions had been so as to leave no portion of the bowel wall uncovered by peritoneum. The wound and the neighbouring portion of the abdominal cavity were irrigated with normal saline at a temperature of 103°, the wound was then sewn up in layers, and a gauze and collodion dressing applied. Mr. Evans said that in this case the diagnosis of acute intestinal obstruction was obvious, the constipation, vomiting, abdominal pain, and distension being well marked. Nothing could be done by palpation, therefore a diagnosis of the cause of the obstruction was impossible, but inasmuch as the patient had had a previous abdominal section, and as adhesions after abdominal section are by no means rare, it seemed not unlikely that there was some causal connection between the previous operation and the obstruction. As to the treatment, there was no room for doubt. No one dreams nowadays, Mr. Evans pointed out, in such a case of doing anything but an abdominal section, though only a few years since a distinguished surgeon advised inversion and shaking under an anæsthetic of such cases. Mr. Evans further remarked that it would have been noticed that he had left a large quantity of saline solution in the abdominal cavity with a temperature several degrees above the normal. The object of doing this was twofold: In the first place, to obviate shock, for this warm fluid would be quickly absorbed and would tend to make up in part for the large amount of fluid lost by vomiting in the two days during which the patient had been able to keep nothing down; there was, however, a further advantage in leaving this fluid in the abdominal cavity; he considered it tended to prevent the formation of adhesion, of the harmfulness of which this case was a striking example. It was obvious, he said, that nothing but an abdominal section could have saved this woman's life, and twenty-four hours' delay might easily have rendered the operation of no avail. Sealing the wound with gauze and collodion was in his opinion decidedly the best method of dressing operation wounds where no drainage was needed, as it minimises the amount of dressing required and permits the wound to be seen without any risk of infection which might occur during redressing.

The subsequent history of the case was uneventful. For a day or two the patient had a little abdominal pain, and she was troubled with slight bronchitis from which she had suffered for some time before operation. She left the hospital three weeks after operation wearing an abdominal belt.

The General Council of the Seine has decided to pension off at an early date the senior (*doyen*) *pharmacien en chef* of the lunatic asylums. The vacancy thus created will not be filled, and the event betokens an impending reform in the pharmaceutical department of the hospitals, a reform which will in various ways effect a considerable aggregate saving.

The annual meeting and dinner of the Brussels Medical Graduates' Association will be held on Thursday, July 13th, at 7 p.m., at the new Gaiety Restaurant, under the presidency of Dr. F. R. Miller. Members desirous of attending are requested to notify the Honorary Secretary, Dr. Edwards, Camberwell House, London, S.E.

An official intimation has been issued that the fifth meeting of the International Congress of Obstetrics and Gynæcology, to have been held at St. Petersburg in September next, has been postponed for a year.

During the week ending June 17th there were 19 cases of typhoid fever notified in Bridgend, and in the previous week there were 13, making a total of 65 cases since the beginning of the outbreak in the third week of May.

An anonymous donation of £500 has been sent to the Bristol Royal Infirmary.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 5, 1905.

INEFFICIENCY OF THE CENTRAL MIDWIVES BOARD.

The machinery of the Central Midwives Board having now been for some time fairly in action, it may be well to inquire whether its methods and achievements are of a satisfactory nature. Its policy and administration have so important a bearing upon the interests of the medical profession that it becomes imperative for the editors of medical journals to keep a close eye upon the proceedings of the Board. It has been our duty from time to time to criticise and at times to impeach the body in question from the day of its inception up to its most recent meeting. We regret to record our opinion that the Central Midwives Board as at present conducted, is an unbusinesslike body run upon lines that must sooner or later bring disaster to midwives and to the medical profession, as well as discredit to those responsible for its official organisation and control. These statements may appear strong, but we feel that matters have come to such a pass that the only chance of getting back to safe and open country lies in the clear and full recognition of the facts of the case. The composition of the committee presents a curious mixture of strength and weakness. The lay members so far as we can see appear to wield a ridiculously disproportionate power in the deliberations of the Board. The fact that they were able to insist upon the supervision of qualified medical examiners by laymen is alone sufficient to stamp the proceedings of the Board as "ill-advised, arbitrary, and to the utmost degree subversive of the reasonable rights and claims of the medical profession." The midwives first prayed humbly to be recognised as a class of lay helpers working under the supervision of properly trained and qualified medical men. Now backed by legislative mandate they claim with an arrogance that rises to sublimity a place superior to the profession, and they have actually established their foothold within the hitherto sacred walls of the medical examination room. It seems almost impossible that a resolution so degrading to the dignity of the medical profession could have been passed under the presidency of a medical man. We regret to record our opinion, however, that not only in the particular matter mentioned, but in many others Dr. Champneys appears to have supported every possible interest except that of his own profession. In him we had hoped to find a President with the requisite strength and tact to discharge the duties of an admittedly delicate post with justice to all concerned. Unless his methods undergo a rapid and complete revision we fear that there will soon be no straw of hope left for our former anticipations to cling to. Time after time those strong and able medical representatives, Sir William Sinclair and Mr. Ward Cousins, have left the Board-room full of angry protest against the way in which important matters were shelved and not infrequently settled in their absence by a "catch" vote. The meetings of the Board are far too few in face of the enormous mass of business that has to be conducted. Instead of close and orderly debate upon points involving important principles the time of the Board is consumed for the most part in wrangling over minor points. The standing Committee business consumes the greater part of the limited time of the meeting. When the routine business of the Board is reached it is time for the country members to catch their trains. Again and again have they raised their voices in emphatic protest against the methods of the Committee as administered by Dr. Champneys. It seems to us that the medical profession should take this matter up seriously and insist that a full and impartial hearing be given to their representatives. To give a specific instance of the unbusinesslike conduct of the Board: the question of fees payable to medical men called in by midwives in times of stress and danger is clearly of crucial importance. The Board meeting held on Thursday last spent several hours over Committee and had scant time to discuss this subject. They declined to fix a fee, and Miss Paget, a lay member of the Board, said that half-a-guinea offered in one instance by a midwife to a medical man was a large sum to come out of a nurse's pocket. Why does not the Board speak out on the matter, and say who ought to pay the fees, and what amount should be paid? In Southend the medical men have determined to charge two guineas whenever called on by a midwife. Equally scant consideration was given to complaints from midwives on the subject of examinations, the number of which had been fixed at previous meetings of the Board with scant attendance and after perfunctory discussion. It would be well for Sir William Sinclair and Mr. Ward Cousins forthwith to give their version to the medical profession in the shape of an informal report.

THE DISCOVERER OF THE CIRCULATION OF THE BLOOD.

FOR so many generations Englishmen have stood firm and solid in the belief that William Harvey was the discoverer of the circulation of the blood, that it is to the average man almost as great a heresy to suggest that Harvey had predecessors as it is to the student of literature to suggest that Shakespeare was not really the author of the plays attributed to him. Nevertheless, there are many patriotic and well-informed people in different parts of the world who are strong in support of other claimants to the honour. It is said that cities contended for the honour of having given birth to Homer, and so countries have contended for the honour of having produced the discoverer of the circulation of the blood. In England three monuments have been raised to the memory of Harvey. In the Anthropological Museum at Madrid stands a monument to Servetus, the Spanish claimant. In Italy the piety of their compatriots has similarly honoured two claimants—Carlo Ruini by a monument at Bologna, and Cæsalpinus, by similar memorials at Pisa and Rome. To Colombo of Cremona others have credited the discovery with no little show of reason. Laying aside all prejudice in the discussion of what is after all a question of historic fact, there is little doubt that all those mentioned and many others—notably Aquapendente and Sarpi—contributed solid blocks to the building on which Harvey placed the coping-stone. The evidence has been very thoroughly re-examined, and summarised by Professor Hemmeter of Baltimore in a recent contribution to the *Johns Hopkins Hospital Bulletin* (May, 1905). From a study of Harvey's own works indeed it is clear that he was aware that previous to his own teaching there was knowledge of the circulation of the blood. He freely uses his right as a man of science of building on the knowledge of others, as when he quotes the observations of Colombo that the blood in passing from the right to the left heart does not traverse the septum, but is carried a long circuit through the lungs. He tells too, that he got his first suggestion of the circulation from Aquapendente whose pupil he was at Padua for some years. He mentions in a letter to a friend that Sarpi in 1623, five years prior to the publication of his own work, put in writing his proof of the uninterrupted return of blood to the heart. It would appear, indeed, that after Galen the first great step toward the discovery of the circulation was made by Servetus, who, in 1553, published in his work *Christianismi Restitutio*, for which he was burnt at the stake by Calvin, a description of the pulmonary circulation. Colombo's observations, quoted by Harvey, were independent of, though contemporary with, those of Servetus. In 1571 Cæsalpinus published a description of the circulation of the blood, both pulmonary and systemic, and twenty years later he gave the experimental proof of his theory. What then was left for Harvey?

There is no doubt that it is to Harvey we owe the complete picture of the circulation. He put together, he unified, he made reasonable and clear, he completed as a system, what had previously been merely the obscure studies of secluded students. He, in fact, proved with marvellous method and cogency, adding illuminating reflections, what, without him would have been lost as hap-hazard remarks whose importance had never been recognised. The harvest, as Tollin says, was ripe for the cutting, but it was necessary to find a Harvey as reaper.

PATENT MEDICINE SUPERVISION.

The unrestricted sale of patent medicines in this country is one of the most glaring scandals that ever cried out for removal. The trade is far from being one of the decaying industries of which so much was heard a year or so ago; it is perhaps the most flourishing, and certainly the most profitable, of the day. A patent medicine that does not find enough dolts to pay for its advertisements must have been very badly put on the market, and a patent medicine that does not show a few hundreds per cent. profit on its sales must have been badly chosen for exploitation. In fact, it is an open secret that the expense attached to pushing a patent medicine is not the cost of material or manufacture, but that of advertising. The sums that are paid to bring the knowledge of the virtue of these preparations continually under people's noses are enormous, and without them the trashy stuff that provides the "literary" matter of the cheap magazine would not be available for the delectation of the man in the street, or the servant girl in the kitchen. The removal of the paper duties, which included the tax on advertisements, enabled the penny and even the half-penny paper to pay its way, but it incidentally gave rein to the patent medicine business, and the patent medicine business now constitutes a cardinal factor in the newspaper proprietor's calculations. Most of the better papers have ceased to accept these advertisements, which, under an ingenious veil, advocate immorality and crime, but we doubt if there are any which refuse advertisements because they are packed with palpable lies, or because they obviously aim at deception. The inquest that ended at Stoke Newington on June 26th, after two adjournments, should prove a warning to those whose eyes it may have happened to catch, and if among them are to be found any newspaper proprietors who admit wholesale advertisements of secret remedies, so much the better will it be. At that inquest the cause of death of two little girls, aged two and three years respectively, was enquired into. They were sisters, and had both died soon after taking, at the administration of their parents, doses of a preparation called "Liquozone," a free sample of which had been obtained by the father. Additional suspicion had been aroused as to the culpability of this preparation by the fact that both the parents had taken some of it, and felt unwell afterwards. Liquozone is a patent medicine which has been largely advertised of late, with rather more than the usual allurements to purchasers, the British Liquozone Company offering free sample bottles to those who wish to try it. The advertisements state that £100,000 is being spent in providing a million of these sample bottles, and announcing the "offer," and it seems not unlikely that some such sum is actually being devoted to its sale, knowing as one does the capital that is often sunk in such enterprises. Liquozone is said to have been the subject of scientific and chemical research for twenty years, and to have been tested through physicians and hospitals for five. It is said not to be made by compounding drugs, nor with alcohol, but to derive its virtues from a gas—largely oxygen gas. Curiously enough, this gas is said not only to be a germicide of such potency that the proprietors will give £250 for a disease germ that it will not kill, but also to be "food for the nerves and blood." A gas that is a "food" in either the scientific or legal sense is unknown to us, and we therefore must continue to regard "Liquozone," on its own showing, as a drug. Yet in its advertisements we find it stated that "any drug that kills germs is a poison, and it cannot be taken internally.". Therefore it would appear that Liquozone carries the refutation of its own claims on its face. The diseases amenable to the charms of Liquozone are given in columns, and vary from dandruff to dropsy, from bronchitis to piles, and from varicocele to women's diseases. Sufferers, "in justice to themselves," are begged to try Liquozone. At the inquest, it came out that the principal ingredient of the preparation appeared to be sulphurous acid, which Sir Thomas Stevenson stated was only one-nineteenth of the strength of the British Pharmacopœial preparation. He also agreed that the pamphlet of the Liquozone Company could be described without much exaggeration as "nothing but lies." As to the actual cause of death, there was some conflict of opinion, as the *post-mortem* evidence was not very definite, but the jury eventually found that the children died of exhaustion, following vomiting and diarrhœa set up by taking Liquozone, and added that "some representation should be made to the proper authorities to have better supervision of patent medicines." Sulphurous acid, as Sir Thomas Stevenson remarked, is not much given at the present day; it is not pleasant to take, and many other drugs can be given that produce similar therapeutical effects without its corresponding disadvantages. It is not, however, a drug that is looked upon as dangerous in itself, and if it produces serious symptoms in small doses the suspicion arises that it may contain sulphuric acid as an impurity. Whether this was so or not in the case under notice, we are unable to say from the report before us; but the finding of the jury in their rider constitutes a sufficiently grave indictment of the patent medicine trade as at present conducted.

Notes on Current Topics.

The Chicago Drainage Canal.

Our readers will remember that a few years ago the city of Chicago spent some twelve millions sterling in constructing a huge drainage canal to conduct the sewage of the city to the Des Plaines River, and thence to the waters of the Mississippi. Previous to that time sewage had been discharged direct into Lake Michigan, causing pollution of the Chicago drinking water. The intention in building the canal was that a constant flow of lake water should be maintained so as to sweep all sewage into the waters of the Mississippi. In this plan Chicago showed complete disregard for the interests of the many cities lower down that stream, all of which drew their water from it. As a result there is at the present time a gigantic lawsuit pending between St. Louis and Chicago, the former city claiming damages for the pollution of its water-supply. The method was obviously wasteful in the highest degree, but one would have thought that sufficient care would have been taken that as far as Chicago itself would be concerned it would be efficient. Unfortunately this is not the case, for after some unusually heavy rain this spring, the canal, instead of flowing in the direction expected, altered its current and for some days discharged into Lake Michigan. The result is that the water supply of the city has been seriously contaminated, as an enormous amount of solid matter must have been deposited on the lake bottom close to the supply intakes. We understand that it is found impossible to prevent a recurrence of this event, and that the use of the canal for its original purpose will have to be abandoned. It is said, however, that it may be possible to convert it into a navigable waterway between the Lakes and the Mississippi, thereby to some extent recouping the city for its enormous outlay.

Gradual Electrocution.

A painful case, but one of considerable medico-legal importance, was the subject of an inquest at Lambeth on June 20th. An electrical engineer was putting in some extra wires in the basement of a South London house, where an installation of electric light had lately been inserted, and did not return to his fellow-workman at the time when he was expected. The latter went down to remind him that he was late, and saw the unfortunate man drop dead before his eyes. The engineer, when first observed, was found to be holding one of the wires between a pair of pliers, and there is no doubt that he must have been doing so for some time previously. Through neglect of the usual precautions, the current from the main had not been turned off during the supplementary operations, and part of a live wire was seized with the pliers. The ground on which the engineer stood was damp, and instead of the current running to earth it must have continued to pass into his body. A condition of tetanus appears to have been set up, so that the unfortunate victim was, although alive and aware of his danger, unable to release his hold. The current was one of average voltage, namely 220, which in the usual way would not have brought about a fatal result, and would not in this case had it not been for its continued action for some space of time. A Home Office inspector who gave evidence said that it had been ascertained by experiment that 96 was the maximum voltage up to which it was possible to go with certainty of being able to release the grip, but another witness from his own experience put it at a much higher figure. The danger is one that must continually be present in electric-lighting work, and it is difficult to conceive of a more painful and lingering death than one caused by such means.

Consumption and Hair.

There has arisen a prophet in New England who has made public the cause and cure of consumption of the lungs. The cause is the clipping of the locks on the head of man, and the cure the letting them grow. Nothing could be simpler, and nothing could be, according to the prophet in question, Mr. Edward Beckham, by name, more logically established. Having himself contracted tubercle of the lungs, he entered a hospital for consumption in Philadelphia, and while there he noticed a failure of the hair crop in his fellow patients. The riddle was solved. He thereupon let his hair and beard grow, adopted an open air life, cured his disease, and, with true altruism, proceeded to preach the truth to others. Mr. Beckham's argument being however so far of an impeachably empirical nature, it was necessary to establish its rational ground. To him this presented no difficulty. "Hair," he says "supplies the ether which is the nutriment and energiser of the entire brain and nervous system. Man is simply an inverted plant. Hair is to man what roots are to a plant." Could anything more be required? Only a frivolous caviller would suggest that if the hair is producing ether it might be better to preserve it from atmospheric influence, as ethers are likely to be weakened, by aerial dilution. By such reasoning it would be easy to prove that Mr. Beckham should encase himself—or at least his hair—in case of steel against the attacks of an insidious atmosphere.

Country Cottages.

As has been insisted on before in these columns, one of the root-problems of public health is to solve the problem of cheap rural housing. Urban housing questions are complicated enough, but with energetic municipalities and cheap traction, a better era seems to be dawning. On the other hand, so long as the drift of the population is all toward the big towns, so long will urbanisation, with its toll of increased suffering and decreased longevity and health, continue to set its mark on the rising generations. Inexorable economic laws have robbed agricultural districts of much of their prosperity and wealth, and if the labourer is to live in the land at all he must continue to be attracted by superior conditions of comfort to those obtaining in towns; moreover, these conditions must be available to his scanty earnings. Foremost among the labourer's requirements is a decent cottage, and to erect a decent cottage at a figure that will be remunerative is the puzzle of the landowners. Mr. St. Loe Strachey is organising at Letchworth an exhibition of cottages built of different materials and in different styles by various architects and builders, who are allowed a free hand to produce the best result at the most moderate price. Materials of all kinds may be used, and the results will be adjudicated upon by competent judges. It is desirable in every way that any cheap cottage that may be approved will not be banned by the building bye-laws of any district in which an owner wishes to erect one. Important as bye-laws are, and important as sanitary requirements are, there must be elasticity in their application, and it will be a vast pity if the solution of the great problem of rural housing is retarded for want of a little sweet reasonableness.

Treatment of Status Epilepticus.

Some valuable hints on the treatment of status epilepticus are contained in a paper by Dr. Arthur Morton in the *Boston Medical and Surgical Journal* of June 15th. Dr. Morton is assistant physician to the Massachusetts Hospital for Epileptics, and he has the need for some effective means of dealing with this dangerous condition frequently before his eyes. After long-continued experiments he has found the subcutaneous injection of bromide, especially sodium bromide, not only when an attack is threatening, but also when the status is established, an important resource. He deprecates the use of stronger solutions than that of thirty grains to the ounce, as irritation is apt to be set up if the solution is too powerful, and this irritation may lead on to abscess-formation. The best site for the injection is just below the angle of the scapula, and the dose may be carried up to a hundred and eighty grains, although generally sixty or a hundred grains are found sufficient. The nurses at the Massachusetts Hospital have directions that when certain patients, who are subject to have fits in series, are taken with two convulsions following each other, that twelve grains of sodium bromide in solution are to be injected at once. If this be not successful, the dose is repeated after each convulsion, till forty-eight grains have been given, when, if status continues, the physician is sent for and thirty to a hundred and twenty grains are given by means of an antitoxin syringe. Dr. Morton has also found lumbar puncture successful in four cases out of seven, after bromide injections had failed. In one of these, patients who had had twenty-five convulsions, after the withdrawal of 20 cc. of cerebro-spinal fluid, thirty grains of sodium bromide in solution were thrown into the subdural space, with happy results. Status epilepticus is not frequently met with in the usual round of practice, but it is so dangerous a condition that the experience of Dr. Morton is well worth attention.

The Organism of Scarlatina.

Some year or two ago Mallory attracted considerable attention by his description of certain protozoa or protozoon-like bodies discovered by him in the skin of patients dead of scarlet fever. The bodies were from two to six microns in diameter and while some were mere oval or lobulated masses others presented a definite rosette-like appearance. This latter form suggested a similarity to the organism of malaria, and as the bodies had not been observed in any other condition than scarlatina Mallory assumes that they were present as the cause of that disease. Some little time later very similar results were arrived at by Duval, who, however discovered the bodies in blisters on scarlatina patients during life. Many intermediate forms were also demonstrated by him, suggesting the cycle of development of a protozoon. So far observation was quite in favour of regarding the bodies observed as the causal organisms of scarlet fever, although in the absence of artificial cultivation a much wider field of experiment would have been necessary. Quite recently however, observations made by Field seem to nullify those of Mallory and Duval, for while he agrees with them in finding the bodies described in the skin and blisters of scarlatina, he has also found them in measles, and he has entirely failed to find them in the skin in the stage of rash of scarlatina. Moreover, it occurred to him that the bodies observed might be leucocytes in course of degeneration, and this hypothesis was borne out by further investigation. He succeeded in fact, by suspending leucocytes in serum, in producing rosette-bodies, and other forms indistinguishable from those observed by himself and Mallory and Duval in scarlatina. While the question can hardly be regarded as quite settled, Field's observations have given a decided set-back to the protozoon theory of scarlatina.

Vaccination Proficiency.

An order issued by the Local Government Board to the various Boards of Guardians on June 12th removes one source of needless irritation and trouble from the path of medical men who may be candidates for appointments as public vaccinators. Hitherto it has been necessary, as a condition precedent to appointment, that such a candidate should produce a certificate of proficiency in vaccination, granted after instruction and examination, unless the body from whom he received his diploma had already required such a certificate as part of his qualification to practise. This provision has meant that many men who had been in practice for years and had vaccinated hundreds of their own patients could not become public vaccinators till they had undergone an irritating course of "instruction" and examination in the simplest surgical operation that falls to the lot of medical practitioners. Moreover, to men not possessing such a certificate, its absence was a severe handicap in applying for the post of public vaccinator. The Local Government Board has now been pleased to relent, and allow such a certificate to be granted after examination only in the case of men who have been in practice, and they will not now have to undergo the farce of "instruction" in a little art of which they are probably past-masters. But the examination is still necessary, and a list of medical men who are competent to grant the certificates is given with great solemnity. For our own part we should have thought that a man who was not fit to perform a primary vaccination on his own account, was not fit to undertake any other surgical procedure.

Knighthood for Dr. William Smyly.

In the list of birthday honours published a few days ago is found the name of Dr. William J. Smyly, of Dublin, the present President of the Royal College of Physicians in Ireland. It may be taken that the knighthood conferred on Dr. Smyly is not merely a compliment to the College of which he is head, but is a mark of distinction to himself personally, as one of the leading exponents of the Dublin School of Midwifery. It is not often that the College of Physicians selects an Obstetric Physician as President, and when the Fellows elected Dr. Smyly as second obstetrician in succession—his immediate predecessor being Sir Arthur Macan—they had a due sense of the lustre shed on Irish medicine by the Dublin School of Midwifery. Dr. Smyly is a native of Dublin, being a younger brother of the late Sir Philip Smyly, and is about fifty-five years of age. He graduated with a silver medal in natural science in Trinity College in 1871, and afterwards studied in Vienna. He was Master of the Rotunda Hospital from 1889 to 1896, and during his term of office much was done to carry on the line of improvements begun by his predecessor, Sir Arthur Macan. In particular it was during his mastership that the Auxiliary for gynæcological diseases was built and opened. Dr. Smyly has been President of several of the gynæcological and obstetric societies, and has contributed valuable papers to the medical journals. On his retirement from the Rotunda he was appointed gynæcologist to the Adelaide Hospital. We join his many friends in hearty congratulations on his new distinction.

Health of the Army.

The ponderous annual report on the health of the Army has just been issued, just eighteen months after the completion of the year to which it refers—namely, 1903. It contains but few fresh features, as though the figures under each head show slight variations—and these generally favourable ones—the old object-lessons are still present. Of these latter, venereal disease is, as usual, sadly to the fore. In India, although the strength has been reduced by 31·9 per 1,000, the admission-rate for venereal disease stands at the appalling figure of 249·5 per 1,000. It is comforting to think that the "general, commanding, regimental, and medical officers are strenuously working in concert by every means in their power to reduce it," but it is difficult to see what practical steps are within their powers. With human nature what it is, and prostitution conducted under the conditions that obtain, it is likely that this lamentable proportion, over a quarter of the full strength of European Army, will be annually in hospital with the diseases which can most truly be classed as preventible, and which bring untold misery not only to the victims in after-life, but often to their wives and offspring. Nor is it reassuring to read that out of 69,553 recruits that were inspected, no less than 22,382 were rejected as physically unfit. This means that practically a third of the presumably healthy young men prepared to serve their country are not of sufficient physique and stamina to do so, and the return for the year under notice shows a proportion of rejections higher by 14·61 per 1,000 than the previous one. Perhaps the most encouraging feature of the report is the strong way in which the Director-General speaks of the possibility of reducing the enteric fever returns. If Surgeon-General Keogh can induce his military colleagues to take this matter seriously in hand, he will have deserved well of the nation.

Death from Liquozone.

The danger of many widely advertised proprietary preparations, although well-known to the medical profession, has not hitherto led to adequate legislative measures to protect the community. An apt illustration of the terrible risks incurred by self-medication with powerful drugs has recently been furnished in Dr. Wynn Westcott's Coroner's Court in Stoke Newington. Two children were dosed for several days with a patent medicine sold under the name of Liquozone, when they died. Dr. F. J. Smith, the well-known medico-legal authority, had no hesitation in ascribing death in both cases to Liquozone, which contained sulphurous acid. Sir Thomas Stevenson supplied the further explanation that small doses might do no harm, whereas continued dosing would have an irritant action. This explains the assertion of the proprietors of Liquozone that millions of bottles have been sold without any complaint having arisen. That fact, however, does not justify the sale of so potent a drug, or for that matter of any drug whatever for the cure of disease by non-medical persons. In this case the jury found that Liquozone killed the two children, and from that view we find it impossible to differ. An extraordinary feature of the case was that two eminent medical men—namely, Professor H. T. Pepper and Dr. Luff, came forward apparently to give evidence in favour of the company. Mr. Pepper stated he could find no traces of an irritant poison; while Dr. Luff went so far as to say, if we may accept the newspaper reports, that in his opinion death was due to food poisoning, and in no way to be attributed to Liquozone. This difference of medical opinion is derogatory alike to the dignity of the profession and to the position of modern medical science.

Professional Philanthropy.

The Chairman of the London Hospital, the Hon. Sydney Holland, has the courage of his opinions. On various occasions we have differed from his views, especially on the matter of the pay system in hospitals. His latest outspoken criticism is a scathing exposure in the *British Journal of Nursing* of the methods adopted by the *Hospital* journal to secure advertisements from medical charities. He quotes a letter from the canvassers of the *Hospital* saying that the sole design of the recent special Sunday supplement was to serve the voluntary institutions, and that consequently the charges made for appeals were nominal. Mr. Holland appends scales of rates charged to hospitals for advertisements in special issues of the *Hospital* and compares them with charges made to tradesmen. A whole page charge for a hospital is £7 7s., against £5 to a tradesman, or £4 if the latter applies through an agent. If we may accept these facts, they show conclusively that philanthropy does not extend to the business conduct of philanthropic journals. The plain truth of the whole matter is that the enormous income and expenditure of the medical charities furnish annually a huge interest in the way of salaries, posts, contracts, investments, and paid legal services, not to mention other patronage. Fortunes are made and titles secured by a great host of social and commercial parasites of our great voluntary hospital system. When will Mr. Holland turn his attention to the economic relations of the general practitioner to the hospitals?

Mr. Coroner Troutbeck on Rash Medical Testimony.

Mr. Coroner Troutbeck continues to urge war to the knife against the medical men of his district. His attitude is inconsistent, for on the one hand he trusts implicitly to the medical witness of his election, a self-constituted pathological "expert," while on the other he rejects the medical men of a vast London quarter. Last week this sapient Coroner held an inquest on the body of a child of 19 months, who died soon after an operation for adenoids. A *post-mortem* examination showed the actual cause of death to have been suffocation owing to the child having swallowed some milk into the windpipe. Dr. Freyberger made that momentous discovery, but surely it did not require an expert at a two-guinea fee to disclose what would have been evident to the veriest tyro in medicine. The Coroner, fortified by this testimony from his talented protégé, proceeded to attack an absent medical man on the strength of the hearsay testimony of his own court officer. He told the jury that while inquiries were being made a certain doctor made a statement which appeared to him to be particularly rash, to the effect that the child had died of blood poisoning following operation. It seems to us particularly rash for anyone acting in a semi-judicial capacity to make public and sinister attacks founded upon remote hearsay evidence. We are glad to believe the methods of most of his Majesty's Coroners are more dignified and more in accordance with the dictates of elementary justice.

Antitoxic Action of Tears.

The immunity of the conjunctival sac to many diseases has suggested to various observers the possibility that the tears may possess some antiseptic action. Although the conjunctiva usually contains a considerable number of germs, it does not contain by any means so many as the mouth or nose. To some infections, such as gonorrhœa, it offers an easy foothold, while to others, such as diphtheria, there is evidently considerable resistance. Demaria, who has chosen the organism of diphtheria for a series of experiments with the lachrymal secretion, has come to the conclusion that the protective action of the tears is entirely mechanical. For instance, when tears were mixed with a culture of virulent bacilli, neither the activity nor the number of the bacilli was diminished. On the other hand, if tears were mixed with diphtheria toxin, and the mixture allowed to stand for some hours, it was found to be comparatively harmless. This result, however, was thought to be due to some chemical action, as no decrease of toxicity was noticed when the toxin and the tears were injected immediately after mixture. It is probable then that it is merely by washing the eye that tears give us protection against bacterial infection.

Eugenics.

The study of the improvement of the human race by selected breeding has, in recent times, been dignified as a science under the title heading this paragraph. The glib argument is applied that as we improve the race of racehorses or greyhounds, for example, by selection of parents, we might produce similar effects by supervising human marriages. There are, however, several fallacies in this reasoning. The two cases are not, to quote Mr. Balfour's Latin, *in pari materia.* We are able to breed fast racehorses because we want fast racehorses, just as we could breed racing men if we so chose; but the difficulty is that we do not know what ideal of man we should aim at, as no one is able to tell what type is most suitable for survival. Is it the muscular man, the tall man, the short man, or the man of contemptible physique but giant intellect ? If any one of these were the type we wished to perpetuate, we might be able to take some steps toward the desired end, but there is no agreement as to the type. Moreover, even if there were a general consensus of opinion, it would not necessarily establish itself as correct. To judge of the most suitable type we should have to know the future environment, which is impossible. Commenting on this subject, out contemporary, *American Medicine*, remarks : " If primitive man could have thought on the subject at all, he would have scouted the idea that a weakling with a hairless body would ever be the best type for survival." In the natural tendency of each individual to mate with its opposite is to be found the great safeguard of the persistence of the human race, as it is by maintaining the normal, and not by promoting wide variations, that a species is perpetuated. Although, therefore, a cut-and-dry " eugenic " system is not likely to present any advantage over natural selection, this view is by no means an excuse for the propagation of the obviously unfit.

The Old and Tattered Prescription.

A recent fatality in which a waiter succumbed to heart disease serves to illustrate the danger that may arise from taking medicine made up year after year from an old prescription. The man in the street loves such a document, especially if to it be attached the name of a well-known physician or surgeon, and cherishes it as an heirloom little short of omnipotent in its healing virtue. That constitutions change with years matters to him not one jot ; the mystic receipt, with its cabalistic inscription, still retains its potent original charm, and must be a priceless remedy for all time. There are two chief dangers attending the use of an out-of-date prescription, one affecting the original patient and the other his friends. The continual repetition of a medicine by the same individual is most unwise—for not only may it gradually lose its effect in certain cases, but it may prove positively harmful. Powerful drugs, such as morphia, mercury, or the nitrites, are given to produce distinct temporary effects, and to continue the administration of these remedies apart from medical supervision is to court an inquest, as the above case unhappily shows. Another common and no less disastrous abuse is the practice of handing a prescription to one's friends who are supposed to be suffering from similar complaints. " One man's medicine, another's poison " is a true alternative reading of a familiar proverb that the public would do well to ponder.

Epsom College Jubilee.

On Saturday last, Epsom College celebrated its " Jubilee." Old boys and friends journeyed from far and near to gather on the cricket-field and in the buildings of the red-brick school on the edge of the Downs. A special service of thanksgiving was held in the College Chapel. Tea was served in the headmaster's garden. In the evening, Mr Henry Morris, F.R.C.S., presided at a festival dinner, and among the guests and friends were the Earl of Rosebery, Sir Richard Douglas-Powell (President of the Royal College of Physicians), Sir C. Holman (Treasurer of the College), Dr. F. de Havilland Hall, Dr. Frederick Taylor, Dr. T. N. Kelynack, and Surgeon-General Branfoot. There was a large muster of old Epsomians. Mr. Morris, in proposing the toast of the evening, " Success to Epsom College," sketched the history of the College and its close relationship to the medical profession, and the Earl of Rosebery in reply spoke in the most eulogistic terms of the record which Epsom College in its fifty years' life had established.

PERSONAL.

On Saturday last the King and Queen, accompanied by the Princess Victoria, drove to Millbank to inspect the new military hospital for the reception of invalids from the whole of the London garrison. Their Majesties made a minute inspection of the buildings, including the wards, in which there were 80 patients. The hospital, when complete, will accommodate 230 patients.

Princess Christian, on the 1st instant, presented the Mary Kingsley medal of the Liverpool School of Tropical Medicine to the following gentlemen :—Dr. Laveran, of the Pasteur Institute ; Sir Patrick Manson, and Colonel Bruce.

The tenth session of the International Statistical Institute will be held in London at the Imperial Institute, South Kensington, from July 31st to August 5th next. The Honorary President of the Society, H.R.H. the Prince of Wales, has consented to act as Honorary President of the Congress, and to preside at the opening meeting on Monday, July 31st, at 11 a.m.

Her Royal Highness Princess Christian attended a meeting last week at Chelsea House at which an appeal was made for a sum of £50,000 to build the first of the sanatoria which it is intended to establish in Great Britain for the open-air treatment of members of the working classes suffering from tuberculosis.

Dr. McCall Anderson, the recipient of a knighthood on his Majesty's birthday list last week, is, of course the well-known Regius Professor of Medicine in the University of Glasgow, and representative of the University on the General Medical Council.

Dr. Thos. F. Chavasse, who was honoured with a knighthood on the same occasion, is senior surgeon to the Birmingham General Hospital, and Consulting Surgeon to several other charities, as well as an author of several well-known medical works.

Dr. W. J. Smyly, another member of the profession selected for titular honour, is the popular President of the Royal College of Physicians, Ireland, and a former President of the Royal Academy of Medicine and of the British Gynæcological Society.

Among the colonial honours conferred last week, Edmond Sinclair Stevenson, Esq., M.D., M.R.C.S.E., Member of the Medical Council of the Colony of the Cape of Good Hope, was knighted, and William Thomas Prout, Esq., M.B., Principal Medical Officer, Colony of Sierra Leone, also Surgeon-General William Launcelotte Gubbins, M.V.O., Principal Medical Officer Western Command, India, were made Companions of the Bath.

Dr. Richard G. Hebb, for many years Pathologist and Lecturer on Pathology at Westminster Hospital, has recently been appointed full Physician of the Hospital.

Sir John Gorst delivered an address last week at the annual distribution of prizes to the students of the Medical School of St. Mary's Hospital, London.

Mr. H. T. Butlin, F.R.C.S., distributed the prizes last week to the successful students of the London School of Medicine for Women.

The name of Admiral Togo appears on the list of life governors of Tilbury Cottage Hospital. Some years ago several Japanese sailors, injured in an accident at Tilbury Docks, were taken to the hospital, and they were there visited by Admiral (then Captain) Togo, who was a naval attaché at the time.

Professor Emil Zuckerkanhdl, who holds the Chair of Anatomy formerly occupied by the famous Hyrtl, has again been elected Dean of the Medical Faculty in Vienna for 1905–6. He was called to this post of honour six years ago.

The Council of Birmingham University has decided to invite Sir Archibald Geikie to deliver the Huxley Lecture in 1906.

Dr. G. H. Pooley, Medical Officer of the East Africa Protectorate and Uganda, has resigned his appointment.

A presentation was made to Dr. Ronald C. Macfie by the patients and staff of the Sidlaw Sanatorium on the occasion of his vacating the office of medical superintendent which he has held since the opening of the institution.

Dr. J. D. Small, Medical Officer, Lagos, has been transferred to Southern Nigeria as Senior Medical Officer.

Dr. A. D. Milne, Assistant Principal Medical Officer of the East Africa Protectorate, has arrived in England on leave of absence.

Dr. Robert Morton, of Nenagh, has for some time been ill, and as a mark of the high esteem in which he is held by all who know him as a friend and a practitioner, he has been presented with a cheque for over £400, and an address. Dr. Morton is one of the most able practitioners in Ireland.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

Midwifery Chair in the University of Edinburgh.—The question of the division of this chair into two departments of obstetrics and gynæcology has, it is understood, been remitted to the University Court. Should they decide that such a course is feasible, either by the creation of a lectureship in gynæcology or otherwise, the necessary legal formalities may require more time than will elapse between now and the beginning of the University winter session, and therefore it is possible that Professor Simpson may be appealed to to continue in office for another six months, pending the reconstruction of his department. We believe that, having made the wrench involved in resigning his post, he is unwilling to do this, for obvious and natural reasons, but is prepared to sacrifice his personal inclinations if need be in order to facilitate the consummation of what he himself advocated in an introductory address to his class so far back as in 1882—*viz.*, the creation of a separate professorship of gynæcology.

Glasgow and Infantile Mortality.—There has been established at Glasgow recently a new milk depot, which provides pure milk for children. As it is a fact that the proportion of deaths during infancy is much greater than at any other period, it is hoped that this new depot, where absolutely pure milk can be obtained, will be the means of diminishing the death-rate of children. The great thing that has hindered the work of the Health Committee of Glasgow in its endeavours to cope with this matter, has been the ignorance displayed by mothers in the choice of food for their children. The health authorities of Manchester and some other towns have been splendidly helped by bands of ladies, who go into the slums and teach mothers the proper food with which to feed their children. Some such plan is under consideration in Glasgow, and a start in the work may be looked for some time in the near future. The health sub-committee have before them a proposal to include among the duties of the female sanitary inspectors that of instilling into the minds of the poor the great improvement which would be effected in the health of their children, if milk obtained from this new milk depot were given to them.

Vaccination and Small-pox.—In his report for the year 1904, Dr. Wm. S. Cook, medical officer of health for Greenock, gave some interesting comparisons between the effects of small-pox on persons vaccinated and those unvaccinated. Amongst all those who were re-vaccinated during the recent epidemic in Greenock, there was not a single case of small-pox. Those persons who were in contact with the disease were all re-vaccinated, and not one took the disease; surely a splendid testimonial to the efficacy of vaccination. Of a thousand people in Greenock who had good marks of early vaccination, only 3.4 took smallpox, while of a thousand persons who had not been vaccinated, or who showed only faint marks of early vaccination, 19.8 were stricken by the disease—almost six times as many. In the case of those who took the disease, 13.9 per cent. of those vaccinated had a very severe attack, while 62 per cent. of persons with no marks had the disease in a severe form. There were only four deaths amongst those vaccinated, out of 215 cases, and two of these deaths were from complications; while there were twelve deaths out of fifty cases of small-pox in those unvaccinated. Dr. Cook finished up by saying that he had obtained good proof from the recent epidemic that, even though the effect of vaccination as a protective agency against small-pox diminished as a person drew towards middle life—if not re-vaccinated—a vaccinated person would not take the disease in a severe form, and there was very little danger of an attack proving fatal.

Knighthood to Professor T. McCall Anderson.—We offer congratulations to Dr. T. McCall Anderson on the bestowal on him of the honour of knighthood on the occasion of the King's birthday. He is Professor of the Practice of Medicine in Glasgow University, a post he obtained in 1900 on the resignation of Sir William T. Gairdner, who is now enjoying well-earned retirement in Edinburgh. Glasgow University has now on its staff three medical professors possessing the title of knighthood; they are Sir Wm. MacEwan, the distinguished Professor of Surgery; Sir Hector Cameron, Professor of Clinical Surgery; and now Sir T. McCall Anderson.

BELFAST.

The Sewage Disposal Problem.—The recent spell of hot weather has brought the sewage question prominently before the Belfast public, as the stench from the shores of the lough has been quite overpowering on some days. Since the city sewage has been discharged directly into the lough by a covered channel which takes it about a mile below the city there has been a great increase in the growth of the common green seaweed (*Ulva Latissima*) on the slob-lands between high and low water-marks. This weed has been shown by Professor Letts, of Queen's College, who has investigated the whole subject, to contain sulphur, and when it decays on the shore it gives off sulphuretted hydrogen in abundance; hence the "foreshore nuisance." The civic authorities have been experimenting, under the guidance of Professor Letts, with a view to discovering some method of treating the sewage that would render it a less suitable medium for the growth of this weed, and with this end in view have laid out bacteria beds covering about four acres. These are to be largely extended, and the inhabitants of the low part of the city close to where these beds are situated are up in arms, petitioning the Local Government Board against them. It appears from the accounts that are given by these protesting citizens that the smell from the bacteria beds is quite as bad as, if not worse than, that from the *Ulva Latissima*. Without dogmatising on the methods employed, one may safely say that it is clear that the satisfactory method of dealing with the sewage of Belfast has yet to be found.

OVERCROWDING OF BELFAST WORKHOUSE.—The guardians have prepared a long report on this subject, in reply to the one sent in by the Local Government Board inspector, and recently noticed in this column, which practically amounted to a charge of overcrowding and insufficient accommodation in every department. The reply is much too long to be summarised, but the general drift might be indicated by the immortal sentence: "Don't shoot, colonel; I'll come down."

Correspondence.

THE USE OF PESSARIES UNDER DIFFICULTIES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Having already written more than once in defence of pessaries. I was pleased to read in your last issue Dr. Burton's remarks, with many of which I quite agree. I cannot, however, subscribe to the statement, "The patient can be taught to take the pessary out, clean it, and re-insert it herself." Fancy a patient with retroversion or retroflexion being first able to replace the uterus, and then the pessary in the position it had been placed by the practitioner, perhaps days before! Dr. Burton says, "I have had numbers of patients who have taken them out every night and put them back in the morning before rising from bed." It would be interesting to know what the pessary was worn for? more especially if the patient is "enjoined to lie in the *horizontal* position" (I presume on the back, unless specially directed not to), which Dr. Burton says nothing about. If all patients wearing pessaries could "take them out" and replace to their own comfort, the visits to the practitioner (at least, in private practice) would become fewer than ever.

The sweeping statement that "no man will be successful in these cases without first putting his patient to bed," I deny. I have often succeeded in fitting a pessary (first visit) by making the patient assume the knee-chest position for five minutes or so before introducing the support (with corset and underclothing loose). Emmet says very forcibly—page 316 of his valuable work: "It is scarcely probable that those who object to pessaries will be likely to attribute their failures to some defect within themselves." Yet they may rest assured that such has invariably been the case. It is well to remember that *a healthy uterus cannot become retroflexed or prolapsed*, hence the importance of *treating that organ while at the same time gaining the great advantage of the support in addition* (as one would use a crutch during lameness). I quite agree with the statement of Emmet, which will go far to explain why the vaginal pessary is decried and become unpopular: "The practitioner, to become an expert in fitting a pessary that can do no harm, must have a decided mechanical talent."

I am, sir, yours truly,
London, W. ALEXANDER DUKE.

Obituary.

JAMES MACNABB CUNINGHAM, M.D.ED., LL.D., C.S.I.

THE death took place last week, at Buckingham Palace Mansions of Surgeon-General James Macnabb Cuningham, C.S.I., M.D., LL.D., at the age of 76, who filled for many years the highest medical and sanitary positions in India, and who had been on the list of honorary surgeons to the Sovereign since 1888. Dr. Cuningham joined the Bengal Medical Service 54 years ago, and, after holding various district appointments, became Secretary to the Sanitary Commissioner and Professor of Hygiene in the Calcutta Medical College in 1869. Three years later he was appointed Sanitary Commissioner of Bengal, and in 1875 received charge of the Sanitary Department for the whole o India. When he retired, in 1885, he was awarded a Companionship of the Star of India, and three years later he became honorary surgeon to Queen Victoria

GEORGE FREDERICK WALES, L.R.C.P. & S. ED.

WE regret to record the death of Dr. George Frederick Wales, one of the founders of the White Star Line and sixty years a qualified practitioner, at Holywood, near Belfast, at an advanced age. In 1880 he graduated L.R.C.P. & S. Edin., and was a voluminous writer on medical subjects, and a former president of the Ulster Medical Society. Three sons have adopted their father's profession, whilst a fourth holds a prominent position in the Chinese Customs. The deceased and the late Sir Edward Harland were intimate friends and not a little of the success of Messrs. Harland and Wolff, the great Belfast shipbuilders, may be ascribed to his sage advice.

PROFESSOR JOHNN V. MIKULICZ, OF BRESLAU.

OUR Vienna correspondent writes:—Another of the links between past and modern surgery has been broken by the death of Mikulicz, Professor of Surgery at Breslau, the famous Lister of the Continent, a pupil of Billroth, and an energetic supporter of the antiseptic treatment. The Mikulicz-tampon is a popular dressing in both Austria and Germany. Born in 1850 and educated at Vienna he has passed through all the phases necessary to qualify for the lofty position in which he has distinguished himself. He was quiet and retiring in manner and modest in conversation. His operations are legion, though his life has been a short one—fifty-five years. Among his principal operations may be mentioned the thyroid, brain, and stomach. As an author he is prolific and recently commenced a journal with Naunyn, entitled "Beiträge aus den Grenzgebieten der Inneren Medizin und Chirurgie."

Literature.

THE PRINCIPLES AND PRACTICE OF ASEPSIS, (*a*)

IN this small manual the author, Mr. Vallack, describes in simple language a practical system of aseptic surgery. He treats the subject by giving the *rationale* of each detail in the procedure, and by citing the principles, and quoting experiments bearing on this method of surgical technique. The author may be congratulated in bringing out very forcibly many points, the full importance of which are often underrated in general surgical practice.

Mr. Vallack advocates the use of sterilised rubber gloves in septic operations and dressings. In this he agrees with the leading exponents of asepsis, since it has been found, as the author clearly points out, that it is practically impossible to sterilise the hands after contact with septic material. In this connection it is surprising to find that he does not insist upon their use in all cases by the operating surgeon. He

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(*a*) "The Principles and Practice of Asepsis." By Arthur Styles Vallack, M.B. and M.Ch. (Sydney), L.M (Rotunda), Surgeon to the Berrima District Hospital, New South Wales. Pp. x. and 95. London: Bailliere, Tindall and Cox. 1905. Price 2s. 6d. net.

bases his objection on the loss of tactile sense. This objection, as a matter of fact, disappears with practice.

In reference to the sterilisation of ligatures, the author points out the fallacy of assuming that catgut, &c., is sterile, when cultivation experiments give a negative result. In support of this he quotes Klemm's experiments, in which, with the same materials as used in the cultivation experiments, a specific infection was produced by inoculation.

On the whole, it would strike the reader that the author's aseptic technique is not as thorough or comprehensive as that described and practised by many surgeons. For instance, the limited sterilised area in an operation, as described on page 69, involves considerable care and anxiety on the part of the surgeon, while stitching napkins to the edges of the skin round the wound might be considered needlessly severe on the patient. If the sterilised field were larger, both these difficulties would be obviated.

CLINICAL STUDIES IN SYPHILIS. (a)

In spite of its title, this interesting little work contains a large proportion of theory, since it is based on what the author calls the microbe-toxin theory, which, although not proved, is stated by Mr. Ward to be very generally accepted. It must be taken into consideration that Mr. Ward's theories, as theories, are put forward in a very ingenious way, especially with regard to the supposed syphilitic microbe generating the syphilitic toxin, the former remaining fixed, whilst the latter is diffused into the circulation, Colles's law being thus explained. In his description of the initial lesion, we think the author lays too much stress on the question of induration, and also that he gives a somewhat erroneous impression in speaking of the primary sore in its second stage as being a . . . worm-eaten ulcer; we think also that Mr. Ward generalises too much in saying that during the secondary latent period "the primary sore tends to grow larger, more indurated, and more callous," as in the majority of cases, according to general experience, the primary sore is a most insignificant lesion, healing readily and giving no trouble, as, for instance, in women, in whom it is even rare to see more than slight traces of the primary lesion, so little inconvenience has it caused. The portion of this work devoted to treatment is well worthy of perusal by any medical man as the outcome of practical experience.

CLEFT PALATE AND HARELIP. (a)

The chief object of Mr. Edmund Owen's interesting little monograph is evidently, as he himself says, to bring into more general notice the excellent work which has been accomplished in the treatment of cleft palate by Dr. Truman Brophy, the president of the Chicago College of Dental Surgery. Dr. Brophy's method in operating on the cleft palate in infants consists, after paring the edges of the cleft and passing silver sutures through the substance of the maxillæ, in squeezing the maxillæ together, this being facilitated by incising the mucous membrane over each molar process and dividing the maxillæ sufficiently to enable the palatine processes to be thrust into the middle line. Although Dr. Owen says in his preface that he hopes young surgeons may find help in the pages of this little book in overcoming the difficulties of operations on cleft palate, the explanation of the operation by Dr. Brophy's method would not we think, be of as much service to the neophyte as to the surgeon skilled in operations on the palate, but, on the other hand, the description of the operation undertaken after infancy is very lucid, and the chapters on the preparation of the patient and on the care of the child after operation are very practical and instructive. The chapter on the operation for harelip is very interesting. In fact, the whole book teems with hints that should be of great value to every practical surgeon.

DELAFIELD AND PRUDDEN'S PATHOLOGICAL ANATOMY. (a)

The present edition of this well-known pathology has been so thoroughly revised and brought up to date by the addition of new matter and new illustrations that it practically constitutes a new book. The principal changes may be said to be, first and chief, the increased attention paid to "the relationships of pathology to the allied phases of biological science," then the exclusion "of those phases of clinical diagnosis and practical bacteriology" which are usually dealt with in special treatises, the re-writing of the sections on immunity, on the blood, and on the nervous system, and the introduction of a more complete bibliography. Changes have been also made in the authorship of the work, as Dr. Delafield has retired, and Professors Ewing, Wood, and Bailey have assisted in the re-writing of several sections. A large number of illustrations have been added.

The book is divided into three parts, the first dealing with postmortem and other forms of examination, the second with general pathology, and the third with special pathology. A longer chapter than is usual in works of this kind is devoted to the pathology of the female reproductive organs, and we suppose that more space could not be spared. If, in a subsequent edition, it was found possible to deal more fully with the complex subject of genital and ovarian pathology, it would add to the value of the book, for it is a sad fact that there is no really first-class work on the subject in the English language. We note that the author takes the view, in a very brief note, that so-called "deciduoma malignum" is most closely allied to the sarcomata. We think that his views in this respect will probably be modified by more recent literature than that he quotes, and that in his next edition he will agree that this curious tumour is derived from the epithelial coverings of the villi, and is best termed "chorionepithelioma."

For the work as a whole we have nothing but praise, and we regard it as an ideal text-book for the student or medical practitioner.

Laboratory Notes.

HUDSON'S EUMENTHOL JUJUBES.

This preparation comes to us with a reputation already well-established in Queensland (manufactured by G. Hudson, chemist, Ipswich, Australia). The use of sweetmeats as a vehicle for the administration of various drugs to the mucous membranes of the mouth and pharynx constitutes a well-recognised artifice of therapeutics. In this particular instance it appears well suited to its purpose. Menthol, as every one knows, is a powerful antiseptic remedy and bactericide, but it is hardly fitted for use as a gargle or spray to the throat. In the eumenthol jujubes we are presented with a menthol combination at once attractive and efficient, and as reasonably pleasant as any menthol preparation can be rendered for application to the sensitive nerves of taste. These jujubes should be of special service to lecturers, public singers, and speakers, and indeed to all who are called upon to use their voices frequently for prolonged periods.

CYLLIN.

The introduction of Cyllin by the Jeyes' Sanitary Compounds Company marks a departure that bids fair to be of some importance in the future of practical disinfection. The preparation in question is a standardised disinfectant, so that not only its composition is constant, but its disinfectant efficiency guaranteed in accordance with a declared standard. In this way it is stated that cyllin is permanently homogeneous, and that it has a disinfectant efficiency eleven times as great as that of pure carbolic acid when tested against a vigorous culture of the *Bacillus typhosus.* It is clear that the question of price must be considered in relation to efficiency; thus, supposing a disinfectant to cost one shilling a gallon, and cyllin four shillings a gallon, but at the same time eleven times as much of the former is needed as of the latter to do a given amount of work, then it is clear that cyllin would be far cheaper in the long run. The principle of standardisation, however, happily enables us to avoid inividious comparisons. Cyllin is clearly a powerful and efficient disinfectant. It is far less toxic than carbolic acid when taken internally, and is likely to be useful in many internal complaints, and, as far as we can see, this preparation has before it a great field of usefulness.

(a) "Clinical Studies in Syphilis." By Arthur H. Ward, F.R.C.S. Pp. 156. "Medical Times," Limited,

(a) "Cleft Palate and Harelip." (Medical Monograph Series.) By Edmund Owen, M.B., F.R.C.S. Pp. 103. London: Bailliere. Tindall and Cox. Price 2s. 6d.

(a) "A Handbook of Pathological Anatomy and Histology, with an introductory section on Postmortem Examinations, and the Method of Preserving and Examining Dead Tissues." By Francis Delafield, Emeritus Professor of the Practice of Medicine, College of Physicians and Surgeons. Columbia University, and T. Mitchell Prudden, M.D., Professor of Pathology and Director of the Department of Pathology. College of Physicians and Surgeons, Columbia University. Seventh Edition, with 13 full-page plates, and 545 illustrations in the text in black and colours. London: Bailliere, Tindall and Cox. 1905. Price 21s. net.

Medical News.

Medical Fees Under the Midwives Act.

IT has long been felt that some provision should have been made in the Midwives Act for the payment of a medical man who is called in by a midwife. The Cardiff Medical Society and the Cardiff Division of the British Medical Association have both expressed the opinion that the supervising authority should pay a fee to the practitioner called in upon such occasions. In Cardiff the supervising authority is the health committee of the Corporation and the medical officer of health (Dr. E. Walford) is intrusted with the administration of the Act. After conferring with the medical men in the town, the authority has decided to recommend to the Corporation that a fee of one guinea should be paid to a medical practitioner called in by a midwife if he is unable to obtain payment from the patient or from the Board of Guardians. The payment is only to be made, however, in cases of flooding, convulsions, and rupture of the uterus.

Bacteriological Department of the University of Durham.

DURING the last twelve months 1,474 specimens have been examined in the bacteriological department of the University of Durham College of Medicine, Newcastle-upon-Tyne, showing an increase of 352 over the previous year. The great majority of the specimens were examined for the various County Councils and public institutions in the neighbourhood. Out of 774 specimens of sputum examined for tubercle bacilli, 39 per cent. were found to be positive. Out of 421 cases of suspected diphtheria 38 per cent. were found to be positive, whilst from 149 specimens of blood from suspected enteric 47 per cent. were positive. Forty-eight samples of water were examined quantitively for bacteria, and six samples of milk for B. typhosus. Urine was examined in twenty-five cases for B. tuberculosis, with five positive results. Ten specimens of blood were examined for anthrax, with seven positive results. One sample was examined for glanders with a positive result, and one sample of brawn was examined for B. enteritidis, with a positive result.

St. Thomas's Hospital Medical School.—Prize List.

THE annual distribution of prizes to the successful students of this Medical School took place on Wednesday last, when His Grace the Lord Archbishop of Canterbury kindly undertook the duties, and delivered an address. Prize for the Summer Session, 1904.—First year's student, J. A. Clark, College Prize, £15. The principal prizes for the Winter Session, 1904-5, fell as follows:—E. W. Witney, Entrance Science Scholarship, £150.; University Scholarships, £50, C. E. Whitehead. Second year's student: The Wm. Tite Scholarship, £25, W. B. Johnson. Third year's students: The Musgrove Scholarship, £35, R. W. Rix; College Prizes: £20, J. A. Clark; £10, H. A. H. Robson. Medallists in Practical Medicine: G. J. Langley, The Mead Medal; H. R. Dean, The Wainwright Prize; G. J. Langley, The Seymour Graves Toller Prize; C. Ll. Morgan, qualified for Mead Medal. Surgery and Surgical Anatomy.—L. E. C. Norbury, The Cheselden Medal; H. T. Gray, A. W. Hooker, and J. H. Drew qualified for Cheselden Medal. Pathology and Morbid Anatomy.—A. G. Gibson, The Bristowe Medal. Obstetric Medicine.—J. M. Wyatt, the Sutton Sams Memorial Prize. For General Proficiency and Good Conduct.—L. E. C. Norbury, The Treasurer's Gold Medal.

Mount Vernon Hospital for Consumption.

YESTERDAY, Tuesday, July 4th, was the occasion for the gathering of a large party of friends of the Mount Vernon Hospital for Consumption at Northwood, when Princess Christian visited the new country branch and was present at the Garden Party held in the extensive grounds. This most complete sanatorium which has cost over £100,000 is the gift of one who desires to remain anonymous. Although only fourteen miles from London it is situated in delightful country, is readily accessible, and in every way admirably adapted to its purpose. The Committee are appealing for £100,000 to secure means for maintenance.

Death Under Chloroform.

An inquest was held at Workington last week regarding the death of Florence Woodall, æt. 31, wife of the Rev. E. J. Woodall, Baptist minister, who died under chloroform whilst undergoing a slight operation in the morning. Dr. Eadie performed the operation and Dr. M'Kerrow had charge of the chloroform. The medical evidence showed that every precaution was taken, and the jury found that death was due to accidental chloroform poisoning.

King's College Hospital.

THE trustees of the late Miss Marianne Frances Hasker, formerly of St. Leonards-on-Sea, have promised a donation of £20,000 (being part of the residue of her estate) towards the fund for the removal of King's College Hospital to South London. The only conditions imposed are that when the new hospital is built one of the blocks for female patients shall be named after the deceased, and that a brass mural tablet shall be erected thereon recording the benefaction.

Pathological Material Sent by Post.

WE have received the following from the Postmaster-General:—The attention of the Postmaster-General has been drawn to the fact that pathological specimens are frequently sent by post by members of the medical profession and other persons in packets which have not been registered as required by the Post Office regulations. The Postmaster-General desires to give notice that the transmission of such specimens is sanctioned only on the condition that they are handed in at a post-office for transmission by registered letter post, and that they are packed in accordance with the regulations published in the Post Office Guide. These regulations, which are necessary for the protection of the Post Office servants and of the public, provide that any deleterious liquid or substance sent by post must be enclosed in a receptacle, hermetically sealed, which receptacle must itself be placed in a strong wooden, leathern, or metal case, in such a way that it cannot shift about, and with a sufficient quantity of some absorbent material (such as sawdust or cotton-wool) so packed about the receptacle as absolutely to prevent any possible leakage from the packet in the event of damage to the receptacle. The packet must also be marked "Fragile, with care." Any person who sends by post a deleterious liquid or substance for medical examination or analysis otherwise than as provided by these regulations is liable to prosecution, even if he be a patient sending something to his medical adviser for his opinion or a medical practitioner sending something to a laboratory or elsewhere.

Notices to Correspondents, Short Letters, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Miss G. (M.D.Lond.).—The Governor of Algeria is preparing to establish lady doctors, with rooms, salary, &c., for the benefit of the female Mussulman population, who may not see male doctors. He proposes to put others in charge of infirmaries for natives.

Statistician.—The rate of suicide per 1,000,000 is on the increase. In 1861 it was 66; in 1881, 77; in 1891, 85; in 1901, 96; in 1903, 105. Alcohol is the most common predisposing cause.

A SKIRTLESS WASTE.

A microbe sat in the busy street;
  A wretched wee wight was he;
And the tears in floods from his woeful eyes
  Poured silent and frequentlee.
"Alas and alack! I am doomed!" he cried,
  In a voice that was filled with pain,
"On the trailing skirt I may ride no more—
  And my soul is the shrine of pain!"

"My heart turns back to the good old days
  When over the slushy street
The soggy skirt went dragging by,
  In the wake of the twinkling feet;
Oh, good old days, you are gone for aye!
  And I sobbingly shriek and sigh;
For the skirt that once dragged in the filth and mud
  Now travels three inches high!"

Dr. F. (Donibristle).—Prof. Osler's little work on Immorality, which was delivered as an address to his students, has been followed by an article in the "North American Review" for this month on "Science and Immorality," by J. Sanderson Christison.

Mr. C. H. S.—The insertion of your letter would open up a discussion on religious subjects for which our columns are unsuitable, and which it has always been our rule to avoid.

Dr. D. J. Jones.—We hope to have space in our next for your paper on "Food and Feeding in Alcoholism."

Dr. G. M. S.—We understand there is a new edition in the press, but are unable to confirm or negative what you have heard. We can hardly imagine the author of a standard work of such authority to contemplate so complete a metamorphosis

A QUESTION OF TEMPERATURE.

An old darky was taken ill, and called in a physician of his own race. After a time, as there was no sign of improvement, he asked for a white doctor. Soon after arriving, Dr.—— felt the old man's pulse, and then examined his tongue. "Did your other doctor take your temperature?" he asked. "I don't know, boss," replied the sick negro. "I hain't missed anything but my watch as yet."—*Exchange.*

Meetings of the Societies, Lectures, &c.

Wednesday, July 5th.

Obstetrical Society of London (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Boxall, Dr. Fairbairn, Mr. Targett, Dr. Hellier, Dr. Macnaughton-Jones, and Mrs. Boyd. Short Communications:—Mrs. Scharlieb: A Case of Uterine Tumour with (?) Sarcoma or Endothelioma.—Mr. Targett and Mr. Hicks: Malignant Embryoma of Ovary.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. P. J. Freyer: Clinique. (Surgical.) 5.15 p.m. Dr. J. Fawcett: Cancer of the Stomach.

Thursday, July 6th.

North-East London Clinical Society (Tottenham Hospital, N.).—4 p.m. Annual General Meeting.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. D. Sommerville: Errors of Digestion in Relation to Disease.

Mount Vernon Hospital for Consumption and Diseases of the Chest (7 Fitzroy Square, W.)—5 p.m. Lecture: Mr. J. Berry: Foreign Bodies in the Air-passages. (Post-Graduate Course.)

Friday, July 7th.

Ophthalmological Society of the United Kingdom (11 Chandos Street, Cavendish Square, W.).—8 p.m. Card Specimens. 8.30 p.m. Papers:—Mr. C. Worth: Hereditary Influence in Myopia.—Mr. M. S. Mayou: Tubercle of the Iris.—Mr. S. Snell: (1) Sympathetic Ophthalmia (severe), Recovery of Perfect Sight in Exciting and Symphathising Eyes: (2) Cases of Sympathetic Ophthalmitis arising after Enucleation: (3) A Further Instance of Glioma in more than One Member of the same Family.—Mr. Cruise: Microphthalmos.—Mr. Nettleship: (1) Note on the Prognosis in Chronic Serpiginous Ulcer (Mooren's Ulcer) of the Cornea; (2) Sequel to a Case of Oxycephaly or "Tower-Scull," published in 1887, by E. Nettleship. Annual General Meeting.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.)—4 p.m. Mr. S. Stephenson: Clinique. (Eye.)

Thursday, July 13th.

British Gynæcological Society (20 Hanover Square, W.—8 p.m. Dr. Charles Maunsell: (1) A Case of Endothelioma Uteri, illustrated by drawings and microphotographs. (2) An Improved Method of Ventrofixation of the Uterus, illustrated. Dr. H. Macnaughton-Jones: (1) Note on Cyllin as a Post-operative Antiseptic. (2) Note on a Case of Post-operative Parotitis. (3) Note on a Case of Urethral Cyst.

Vacancies.

City and County Borough of Chester.—Medical Officer of Health Salary £500 per annum. Applications to J. H. Dickson, Town Clerk, Chester.

Monmouthshire Asylum, Abergavenny.—Senior Assistant Medical Officer. Salary £250 per annum, with board, furnished apartments, attendance, and washing. Applications to the Medical Superintendent.

North Riding of Yorkshire Lunatic Asylum, Clifton, York.—Medical Superintendent. Salary £600 per annum, with furnished house and allowances. Applications to Robert Holtby, 5 New Street, York.

Gateshead Dispensary.—Assistant Medical Officer.—Salary £160 per annum. Applications to W. Swinburne, Hon. Sec., the Town Hall, Gateshead.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Medical Officer of the Casualty Department. Salary £100 per annum. Luncheon at the Hospital. Applications to W. M. Wilcox, Secretary.

Parish of St. Giles', Camberwell.—Assistant Medical Officer at the Infirmary, Brunswick Square, Camberwell. Salary £110 per annum, with apartments, board and washing. Applications to the Medical Superintendent at the Infirmary.

University of Leeds.—Faculty of Medicine.—Demonstrator of Bacteriology. Salary £150 per annum. Applications to the Registrar of the University.

Royal Victoria Hospital, Bournemouth.—A House Surgeon. Salary £100 per annum, with board and lodging. Applications to J. Wycliffe-Goodwin, Secretary.

Metropolitan Asylums Board, Leavesden Asylum, near Watford. Herts.—Male Third Assistant Medical Officer. Salary £150 per annum, with rations, lodging, attendance, and washing. Applications at the office of the Board, Embankment, London, E.C.

Appointments.

Batten, Frederick E., F.R.C.P.Lond., Physician to the Hospital for Sick Children, Great Ormond Street.

Charles, John Roger, M.A., M.D., B.C.Cantab., M.R.C.P.Lond., M.R.C.S.Eng., Honorary Assistant Physician to the Bristol Royal Infirmary.

Dobson, J. F., M.S.Lond., F.R.C.S.Eng., Honorary Assistant Surgeon to the General Infirmary at Leeds.

Macgilvray, W. Jackson Hooker, L.R.C.P. and L.R.C.S.Edin., &c., Medical Officer to the General Friendly Society, for Higher Broughton, Manchester and District.

Moore, L. A., L.R.C.P.Lond., M.R.C.S., Dental Anæsthetist at the Bristol Royal Infirmary.

Births.

Camps.—On June 28th, at Udney Park, Teddington, Middlesex, the wife of Percy W. L. Camps, M.B., B.S., F.R.C.S., of a son.

Leaning.—On June 22nd, at 23 Rusthall Avenue, Bedford Park, London, the wife of R. Craske Leaning, M.B., B.S., M.R.C.S., of a son.

Marriages.

Evers—Long.—On June 21st, at St. James's, Clapton, Guy Vincent, fourth son of Alfred Evers, White Hall, Stourbridge, to Kathleen Elizabeth, daughter of the late Mark Long, M.D., of Ludlow, Salop, and Mrs. Long, of Cromer Norfolk.

Inman—Turner.—On July 1st, at St. James-the-Lees, Nutley, William Inman, M.B., to Lena Turner, eldest daughter of Albert Turner, The Limes, Nutley, Sussex.

Parsons—Smith.—On July 3rd, at St. Luke's Church, Allan Chilcott Parsons, of the West African Medical Service, eldest son of the late F. J. Parsons, M.R.C.C., of Portland, Dorset, to Agnes Mynfreda Hart Smith, youngest daughter of the Rev. W. Hart Smith, of Launceston, Cornwall.

Power—Stewart.—On June 28th, at Poona, Captain William Martin Power, R.A.M.C., only son of Mrs. Power, of Dublin, to Margaret Emily Campbell Stewart, second daughter of the late Major A. F. Stewart, 36th and 23rd Regiments.

Deaths.

Abercrombie.—On June 27th, at Sherwood, Colinton, Midlothian, Miss Agnes Abercrombie, in her 86th year, last surviving daughter of the late John Abercrombie, M.D. (Edin. and Oxon.), F.R.C.P., first Physician in Scotland to King William IV. and to Queen Victoria.

Evans.—On June 6th, at Lucknow, of heat apoplexy, Staff Sergeant Ernest Haines Evans, aged 28, third son of Herbert N. Evans, M.B., of Seaford, late of Hampstead.

ASSISTANCY WANTED with a view to ultimate partnership or sole charge by a practitioner doubly qualified, aged 31, who has filled the offices of Resident Physician and Surgeon to to one of the largest Infirmaries, and has done a good deal of surgical work. London or Provinces immaterial.—Address, Edin, London Office of this Journal.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, JULY 12, 1905. No. 2.

ABSTRACT OF THE

Cavendish Lectures:

ON

DISEASE OF THE HEART. (a)

By JAMES F. GOODHART, M.D., LL.D., F.R.C.P.,
Consulting Physician to Guy's Hospital and to the Evelina Hospital for Children.

THOSE murmurs with which I shall first concern myself are all systolic. Many are basal, and of these, some are over the aortic valves, but more over the pulmonary, extending over the right ventricle, and towards the apex. Some are loudest in the mitral area, and when so they have a tendency, like the basal murmurs, to diffuse themselves, in this case upwards, round the nipple, to join the basal one, and the two often existing together, the one merges into the other and it is difficult indeed to say if there be one murmur or two. Very often, however, there is a purely apical murmur, which is heard in a series of separate whiffs, or is intensified in whiffs. And these are clearly associated with inspiration. Two or three come in each inspiration, as it rises to its acme, and then cease again, and these may be quite well heard round at the angle of the scapula. They are most marked when the patient is nervous under examination, and the heart more or less quickened. The murmur most probably *disappears* as the heart quiets down, and in all cases it is then much diminished. Under similar circumstances there often occur impurities of sound rather than definite murmurs; the first sound loses its cleanness, and is converted into a murmurous, or humming, or groaning, or grunting prolongation, this being confined almost exclusively to the position of the impulse.

Lastly—and perhaps most common of all—there is another murmur, or the same murmur under a different aspect, again systolic and apical, and curving round it upwards towards the base, and which has this peculiarity, that it is only brought out by making the patient lie down. The heart-sounds, when examined with the patient standing or even sitting, are absolutely healthy, but put the patient on a couch, and a more or less well-marked, often quite loud systolic souffle, like that of mitral regurgitation, is developed round the apex. If a somewhat prolonged observation is made it will be found that the murmur varies considerably in intensity at different beats, and tends on the whole to disappear, after the position assumed has been maintained for some few seconds, or perhaps as much as a minute or two. Much more rarely I have heard a bruit develop when the patient rises, though there has been none when the body was recumbent. Foxwell speaks of this murmur as "the pulmonary murmur," and considers its position to be over the second and third left intercostal spaces. He alludes fully to this characteristic feature of production in the recumbent posture, and explains it by stretching of the pulmonary artery under conditions of debility, and he has even known it to develop after the occurrence of heart strain.

If you make a practice of examining the heart of everyone that you see for the first time—no matter what the complaint—both standing up and lying down, I am quite sure the frequency with which you will find this systolic murmur, or these systolic murmurs, will surprise you; they are as common as movable kidneys.

These are the chief varieties of what are called "functional" murmurs. What, however, is, I think, not even yet so well known as it ought to be, or allowed for in daily practice, is the *frequency* with which they occur even in healthy subjects, unless mere temporary nervous excitement be judged to be ill-health, and this *variability* in *form* both between one case and another, and in the one case also, between one moment and another.

Functional murmurs have ever been supposed to convey the indication that, at any rate, there is something wrong, and mostly a blood change to be removed by an administration of iron. A proportion of them are produced in the mitral orifice; that any one of them may occur in man, woman, boy, or girl, examined it may be casually, and in whom there need be no sign of any disease, or even of disturbance of the action of the heart.

Now it seems fair to argue that being so often discovered haphazard, and associated, as they often are, with no symptoms, and being often called into being by a simple change of position of the body, they cannot be, at any rate in many cases, of first-rate importance, and I would venture to change the name of many of them from the old one of "functional" to that of "postural" murmurs.

Yet such cases are often rejected at life offices; they are refused for the public services; they come from all quarters committed to the existence of organic heart disease. So common, indeed, are such cases that it is impossible to give even a summary of them, but I will single out a few that have specially interested me or have come across my path while I have been preparing this lecture.

A common case is such as this: A tall, overgrown, nervous youth with a pulse of 104 under examination. The dulness is decidedly ample over the left side of the chest inside the nipple, and there is a diffused forcible impulse spread all over the second, third, fourth, and fifth spaces, between the sternum and the left nipple. On auscultation there is a loud systolic murmur over the pulmonary valves, a thick second sound, and at the apex a loud systolic murmur that comes in whiffs as the inspiration rises and disappears absolutely as it wanes. What could sound worse than this description, and the case can easily look grave to the examiner, but the signs need all to be seen with the individual as a background, and then they are clearly of much less importance. Deduct the nervous excitement and the long narrow chest that cramps the lungs and brings the boy's heart unusually to the fore, and then the character of the murmur points to the reasonable probability that the heart is a sound one.

(a) Delivered before the West London Medico-Chir. Society, Friday, June 23rd, 1905.

Another case that interested me much at the time was that of a young man, æt. 22, who, having passed into the Woods and Forests three years before, was rejected at a final medical examination because he had disease of the heart. He was sent to me by Mr. Giffard, of Egham, because he could not find anything wrong. I examined his heart in all positions, and am sure it was absolutely healthy. I was so convinced that the man must have been nervous under examination and that a mistake had been made, that I wrote to the Under-Secretary of State, and he very kindly acceded at once to my request for a re-examination, but the Board adhered to its original opinion, and the candidate was again rejected on the ground that he had a valvular murmur that rendered him unfit for service in India. He had never had any trouble with his heart before, nor has he had any since, for I heard of him not long ago, and I am quite sure there was never anything more than the temporary murmur due to neuro-muscular excitement, and I hold that a young man's prospects were unnecessarily placed in jeopardy by reason of ignorance of the character of this murmur.

Once more, I saw last June a man in the Army, æt. 21. He had been sent home from India with this on his sheet: —He was about to be placed under an anæsthetic for abscess in his foot, and an examination of the heart showed the apex beat in the normal position, but also in the epigastrium, and over the right ventricle. First sound accentuated and accompanied by a blowing systolic murmur over the tricuspid area. The remark appended is that the local signs are in favour of an organic lesion, but the improvement of the man's general health pointed to a functional murmur.

I saw him with his then medical man a month or so after he arrived home, and his symptoms were chiefly a rapid nervous action. I cannot now say if there was any murmur, but I considered it essentially a nervous heart, and that there was no occasion to be anxious about his future. We lost sight of him, and he eventually went out to India again after six months' leave, and as soon as he started work and long and heavy marches he broke down again from, as he told me when I pressed him for definite symptoms, sheer exhaustion, and he was sent home "suffering from *valvular disease*, the effect of climate and duty." The *physical signs*, as recorded on his health sheet, being taken to indicate "organic mitral regurgitation with tricuspid insufficiency." But what do I find? When standing there is absolutely no abnormality of any kind. When recumbent, the heart's action becomes cantering, and there is an impurity of sounds both at the apex and base. The real explanation of the case is that he has never as yet had the stamina required for the Army, and under the stress of climate and duty he becomes played out, not in the heart more than any other muscle, and as soon as he is off duty he recovers himself as he did on the former occasion.

Many a difficulty is there with these cases, and I cannot too strongly urge the necessity of taking a more liberal view of the power of disappearance of even well-marked cardiac murmurs. There is no need to neglect them, or even to make unduly light of them. We do not know, and must wait and see. Such cases need watching and examining from time to time. It is easy to do this without committing one's self to any irrevocable diagnosis or prognosis until time has shown the way. And perhaps this applies with more especial force to childhood than to adult life. Pyrexial disturbances of all sorts are of the commonest of maladies up to ten or twelve years, and there is nothing more common during these attacks than for the first sound of the heart to develop a systolic murmur, in association with the excitement of the muscular action that is one of the common phenomena of fever. Clearly the heart in such cases requires to be kept under careful observation, lest anything escape us of permanent import to the integrity of the organ, but there is no need to excite the apprehensions of the parents. It is a feature of the febrile reaction of childhood, and for the most part these bruits quite disappear as the fever subsides, and the child recovers its tone. In so important a matter as the question of the existence of endocarditis or valvular disease, no one should precipitately commit himself to an opinion from which it will be difficult to extricate either himself or his patient. Let me illustrate this by a case. A child has had an attack of fever of sorts. A systolic murmur has developed, and the heart is said to be affected, and the future sketched out in somewhat sombre light. The fat is all in the fire from the mention of heart's disease, and the necessity for prolonged rest. But the child was not ill; its temperature was not yet stable, and although admittedly there was a systolic murmur audible from time to time, and I think some little displacement of the impulse, I took a much more sanguine view, based upon the grounds I have already given, that the murmur was a variable one, being frequently entirely absent, and that it was also distinctly a postural one. But it was obvious that my opinion was neither expected nor acquiesced in, and I should not be surprised if that child were still undergoing that most harmful process of being shielded from his environment in every possible way because he labours under the suspicion of having disease of the heart.

Within limits rather jealously watched, I should regard dulness as a safer sign of disease than the position of the impulse. Everyone knows that great increase in the size of the heart may be present without any increase of the dulness, and on the other hand, and it is with this that I am more concerned, there may be apparent increase of dulness without any increase of the size of the heart or of its cavities. Increase of the natural præcordial dulness often means no more than an altered relation of the heart to the chest wall or surface; a change in the pulmonary circulation or inflation, and not in the heart itself. For example, in the narrow-chested people of all ages and either sex, although women and children are its best illustrants, the dulness is often large from the simple fact that the lungs are small and not fully inflated, and therefore the heart is much more extensively in contact with the chest wall in front, and under this condition in a nervous subject, to hark back to the former section, it is wonderful how masterful the beat seems to be, and there is indeed excuse for thinking the organ diseased, although it is in truth quite healthy. But then as regards dulness, I would have these remarks apply chiefly to dulness at the base, and over the right side, and very cautiously indeed, if at all, to the region of the apex. I therefore find it impossible to agree with the conclusions of those who, when they detect small differences in this area after baths and other forms of treatment, ascribe it to a reduction in the size of the heart. It seems to me that the Nauheim treatment in appropriate cases—not all and sundry—has indeed the warranty of *results*, but not that of any convincing topographical argument, such as its advocates claim for it.

I come next to a number of cardiac disturbances, which group themselves together under irregularities of action, and as an introduction to the subject I can hardly do better than recall to your minds all the vagaries of the action of the muscular fibre of the heart, that you may hear in any one afternoon, in the out-patient room under the excitement of examination. The noises, the plunges, the thuds, the sudden momentary stops that come; and have you not often wished, as I have done, when, as sometimes happens, the case staggers experience, and when, as I maintain, it is a more vital matter to be able to say positively that there is *no* disease, than to say there *is*, for the happiness of a life is far more linked to the verdict, 'You are *healthy*," than to that other, "You are not quite sound, and you must take care of yourself," for the one means a full life, and the other a maimed one? Have you never wished, I say, that some mechanical genius would invent such a cardiaphone as would enable one to examine that heart as its subject slept, untrammelled by his nerves?

Any of these conditions may be evidence of serious organic disease and a breakdown in the near future, but in themselves they may be simple functional disturbances, and of no great moment. Taken as they come, I think it is not untrue to say that they may be regarded as trivial, or at any rate hopefully, until you have proved them to be otherwise. This applies to some more than to others. Bradycardia and pain are certainly the most ominous, but either may be temporary only. Tachycardia in like manner is often a mere nerve excitement, and of no importance, though under certain circumstances it is a most dangerous disease.

Let me say a few words about each of these separately, and perhaps as most common comes first an irregular or intermitting heart. I know not which is the more common or the less important. A heart that beats irregularly in time is very common as a transient thing. I cannot but think that many own immediately an abdominal origin; that they are caused through some waning influence on the part of the great ganglia of the abdominal nervous system.

And perhaps this will throw some small ray of light upon one or two other maladies which, although we must call them disease, it is questionable whether *qua* heart they are really so. Two are common, two are of pathetic interest, so swift, so tragic may be their ending. I will take them in their order—Graves' disease, angina pectoris, some forms of sudden death. The first-named comes properly next, as in effect it is exactly the same disease as has just been described. It differs in no other way than that it is much more likely to be intractable, and even permanent in some. No better illustration of the need for keeping separate disease and unnatural function could be given, for it will exist for years without producing evidence of disease, and it therefore affords the best possible example of the never-say-die principle that is inherent in the heart, and of the power of that organ to cope, and cope successfully, with very adverse circumstances.

Angina pectoris is not as happy in this respect, but it also has in some respects a similar history. It is well known that when anyone dies of this malady the coronary arteries are almost invariably found diseased, and although it has been a much vexed question, the disease found has come to be considered as its cause. And I think Osler at any rate has stated that in *most* cases carefully examined during life some evidence of disease about the aorta will be found to exist. I demur to both opinions.

Angina pectoris is common among us, if we are on the look-out for the milder forms of it, but then it is not for me a sudden dreadful chest pang that comes and kills within, perhaps, a few hours. That is a rare variety. It is much more a paroxysmal twinge in the epigastrium or chest, that almost invariably takes a man in walking, and apparently because he walks, and because he walks uphill, and moreover it is quite astonishing at how small an incline the anginal patient will shy. He stops and looks into a shop, and within a few seconds the pain will have vanished, and its departure is nearly always associated with the eructation of wind. So much so is this the case that it is often mistaken for a simple indigestion, which is all the more plausible in that it is a common visitant when the walk is taken soon after a meal. It is constantly finding out the city man after his breakfast. It is also a malady that comes and goes, sometimes goes altogether, but is also more usually one of the most intractable of the neuralgiæ with which we are called upon to deal, and too often it has come to stay, with intermissions. And here is the point: I have known it in two cases to last twenty years, so long, indeed that it seems impossible, at least unlikely, that the disease that was found at the last was indeed present at first. I have certainly examined these mild cases by the score without finding any trace of disease of the heart, and all my later experience confirms me in saying what I said years ago in this respect, that the pain is best explained by regarding it as a neuralgia, or storm, that emanates from the great abdominal brain, although I was inclined at one time to regard it as a cramp of the heart.

It might perhaps be thought that the very generally accepted association of vascular tension with angina is adverse to this opinion, and so I think it might be. But I have never yet accepted this view of angina pectoris for more than a small proportion of cases. I say—assured in my own mind that I am right, although it is contrary to the opinion of the most experienced men—that as a rule there is no increase of tension; I have had my finger on the pulse all through a spasm of angina many a time. Angina is, if anything, a disease of low tension, as is to be expected of a crusning pain that emanates from the pit of the stomach.

Now I wonder whether you have followed my drift, for I must confess, as I retrace my own thoughts, that innocence and guilt seem to have been somewhat incongruously mixed; I must often have seemed to have been straining at a gnat and swallowing a camel. Nevertheless, this endeavour to bring within *proper limits*, and only this, the significance of some of the common forms of departure from the normal function of the heart, is directed to the diagnosis, treatment, and prevention of real disease. Discussing a questionable case of heart disease the other day, it was said to me, "There is no *disease*; the heart is only a little dilated and fatty." But what more disease can you ask? It points well my moral, which is this: that all these ailments that I have mentioned, oft-times trivial, oft-times transient, are too often but pegs upon which to hang a diagnosis of dilatation of the heart, and in the present day we make much too free use of this diagnosis. I regard dilatation as one of the worst of all the heart's diseases, and to play with such a term is to play with a torpedo. Surely dilatation, save in exceptional circumstances, should be reserved for a disease that is associated with some series of definite symptoms, not made dependent, as over and over again it has been, upon the mere fact that the impulse can be felt to beat in the nipple line, or even, perhaps, a little beyond it; or upon the presence of a transient murmur.

I must not go so far as to say that dilatation cannot exist without symptoms, for in the obscurity that surrounds sudden death it may be that it can; still, it must surely be an exceptional occurrence, and I think one ought to expect that, ever in slight degrees, some of the signs of a failing circulation should exist, and among these I emphatically do *not* include either giddiness or fainting. Disease of the heart seldom, if ever, causes either. I have often said this before, but it is a point that still needs insisting upon.

But there are other terms in general use that I like little better than this one of dilatation, because they have come to mean too much. One of them is "heart strain."

Years ago there was a discussion at one of the Societies upon aneurysm of the aortic arch, and I having made the remark that it was practically an incurable disease, as judged from the evidence of the *post-mortem* room and the museums—and so it is—Sir William Broadbent promptly and felicitously retorted that the *post-mortem* room was not the place to look for cures! I was quick to see then that what seemed an obvious truism did but dissemble the truth, but to-day, and here I am older and I now see that other face, with fuller meaning, which then perhaps I slighted. And so I have availed myself of the honour you have done me to discourse to-night in other terms upon the buoyancy of life, and to preach that it is not well to seek too much for the dead among the living.

ARTERIAL TENSION IN DISEASE.

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[SPECIALLY REPORTED FOR THE MEDICAL PRESS AND CIRCULAR.]

The study of arterial tension in disease comports two principal divisions—*viz.*, symptoms associated with hypertension and symptoms associated with hypotension. The first thing to do in regard to the first category is to establish a minimum figure beyond which the tension may be considered as excessive, although it is impossible to lay down a hard and fast line, seeing that the average pressure in the radial artery is extremely variable, according to the age of the subject and what we may term the congenital cardio-vascular resistance. Extensive observation justifies us in stating that hypertension exists whenever the sphygmomanometer applied to the radial artery gives a figure higher than 18 cm. of mercury in the adult, and 20 or 21 in the aged.

Symptoms associated with hypertension are frequent in proportion to the very large number of conditions capable of raising arterial tension. The three factors concerned in regulating normal tension—that is to say, an increase in the blood mass, stronger cardiac action and modifications of calibre of the arterioles—may exert their influence, but changes in the peripheral circulation play the foremost part in the production of hypertension, whether the cause act directly on the vessels or induce such change *via* the nervous system. Symptoms associated with hypertension may be due to mechanical, reflex, or toxic causes. Hypertension due to mechanical causes exists only in rare instances, and is of its nature ephemeral. If the increase be moderate in degree, restoration to normal soon takes place, while if it be due to structural changes in the heart or vessels it soon gives place to hypotension in consequence of fatigue of the myocardium. These remarks also apply to hypertension of reflex origin, and more particularly to hypertension of cerebral origin, such, for example, as powerful emotion. It must, however be borne in mind that severe repeated nervous excitement may, in the long run, give rise to general disturbances of nutrition capable of determining permanent auto-intoxications with vascular sclerosis. In such case there is permanent hypertension of complex origin.

Toxic causes may be divided into *endogenous* and *exogenous*. Auto-intoxications associated with hypertension are due to enhanced toxicity of the products of metabolism followed by retention consequent upon reduced activity of the eliminatory or glandular structures. This modification of cellular activity constitutes the bradytrophic diathesis which, though usually hereditary, may be induced in its integrity under the influence of a sedentary life, constipation, overwork, or as a result of intoxication of gastric origin. These facts explain the existence of dyspepsia with hypertension. Pathological modifications of glands with an internal secretion, modifications which may be solely dependent upon phases of organic evolution (puberty or the menopause) may be productive of the same result by slowing the oxidation processes. These causes will act with the greater force in presence of a well-marked, pre-existing bradytrophic heredity with hypertension and arterio-sclerosis.

It is necessary to insist upon the fact that poisons of exogenous origin act in much the same way as those of endogenous origin. Thus, apart from the vascular spasm produced by the direct action of lead, chronic plumbism culminates in such an extreme degree of slowed nutrition that the manifestations resemble those of gout with its uricæmia, periarticular reactions and generalised arterio-sclerosis associated with marked hypertension.

Whatever be the nature of the toxic agent, endogenous or exogenous, the morbid processes may culminate in symptoms of acute intoxication of the same type (uræmia, eclampsia and plumbic headache), so that there is no necessity to invoke any one factor, such as hypertension, to explain the similarity of symptoms, the similarity of action of the toxic causes being itself sufficient to account therefor.

Poisons of microbial origin, exerting, as they do, an acuter and directly degenerative and destructive action, give rise more particularly to phenomena of hypotension. This, however, may be preceded by a period of hypertension, and, on the other hand, certain toxins (staphylococcus aureus, pyocyaneus and mallein) appear to possess pronounced hypertension-producing properties. Whether hypo- or hyper-tensive, microbial poisons—that of scarlet fever especially—determine inflammatory phenomena which persist long after the original cause has disappeared and culminate in generalised arterio-sclerosis specially localised in the heart, kidneys, or brain.

Dissatisfied with the intoxication theory, Dr. Vaquez has raised the question whether, instead of invoking the influence of products of tissue metabolism in general, it would not be better to incriminate one particular hypertensive substance. In view of the well-known influence of suprarenal extract on arterial tension on the one hand, and of the frequency of lesions of the adrenals in infections and intoxications on the other, he has arrived at the conclusion that symptoms associated with hypertension, especially trophic nephritis, may be due to excessive functional activity of the suprarenal glands, just as in the morbid condition described by Sergent and Bernard under the name of *hyperperinephritis.* Personally, though we are not concerned to deny that lesions of the suprarenal glands may have a share in the production of symptoms associated with marked hypertension, we prefer to regard these lesions less as a direct cause of the hypertension than as a defensive reaction against hypertensive poisons.

The evolution of the lesions associated with symptoms of hypertension runs through three phases. The first stage is one of spasm, the functional phase, which may be prolonged, but in the course of which supervenes a purely histological perivascular inflammatory process. This phase corresponds to that described by Huchard as the presclerotic stage, but which would be more accurately designated as the præfibrotic stage. The second stage is that of generalised fibrosis of the small vessels which determines progressive miopragia of the organs; it is the phase of fibro-capillaritis, revealed at the autopsy and capable of detection by careful clinical examination. The last phase is characterised by extension of the fibrotic process to the large vessels—*i.e.*, generalised arterio-sclerosis, followed, sooner or later, by atheroma.

We must also mention the states of partial hypertension which are due, for the most part, to arteritis, but which we cannot deal with exhaustively in the absence of the necessary data. In respect of the symptomatology, we must ask ourselves whether hypertension is *per se* capable of directly determining grave local and general disturbances, such as homonymous hemianopsia, transitory aphasia, amaurosis, headache, glaucoma, and the convulsive crises of uræmia and eclampsia. Dr. Vaquez calls attention to the fact that amaurosis, homonymous hemianopsia, and transitory aphasia present one feature in common—*viz.*, that they coincide with the hypertension and disappear when this subsides. But the exaggeration of the hypertension, together with the symptoms just referred to, may possibly both be explained by a passing intensification of the toxic cause upon which the entire syndrome is dependent. All the active causes in these cases are vaso-constrictive and give rise to spasms observable by the aid of the ophthalmoscope, so that these symptoms and the hypertension are both dependent upon the same mechanism, although the two do not stand to each other in the relationship of cause and effect.

The same reasons hinder our admitting the hypertensive nature of the paroxysmal convulsions of uræmia, eclampsia, plumbism, &c. Moreover, if the purely mechanical theory of uræmic convulsions and eclampsia could be substantiated, it would be difficult to explain the rapid action of bleeding in bringing about the subsidence of the convulsions. The removal of, say, fifteen fluid ounces of blood has little effect on arterial tension, but along with the blood is eliminated a sufficiently large quantity of poison to calm, at any rate, the cortical irritation.

It may be asked whether, in case of generalised arterio-sclerosis with renal lesions, the crises of hypertension may not be determined by the retention of a substance not itself toxic, but exerting a hypertensive action. According to certain authors, the retention of chloride of sodium in the organism is capable of determining this result. Personally, we are unable to concede that such is the case, and we feel justified in maintaining that the hypertension is not due to variations in the elimination of chloride of sodium, but that we are dealing with substances subject to the same laws of retention and elimination as the salt in question.

In view of the very large number of primary and secondary cases of hypertension it is obvious that therapeutical indications must necessarily be complex, and that prophylaxis and general hygiene must be accorded a conspicuous position in the treatment. The recognition of the primordial cause of the hypertension is indispensable, especially in cases of recent intoxication, in which its early removal may suffice to bring about permanent recovery. In cases in which the immediate removal of the cause is not practicable, and in those in which the organism has become deeply impregnated therewith, our only hope lies in organotherapy which exerts an unquestionable antitoxic action. With regard to infectious diseases, which are usually associated with hypertension when fully developed, the treatment must be continued after apparent recovery in order to prevent, or to bring about, the immediate subsidence of sclerotic processes leading to hypertension. The treatment must be particularly energetic in diseases which, like scarlet fever, are powerfully hypertensive and sclerogenous from their onset.

The alimentary *regimen* indisputably occupies a foremost place in the therapeusis of hypertension. Not only must gastronomic excesses be forbidden, but we must also avoid all causes capable of increasing the spasm or of provoking or aggravating the sclerosis. In cases of renal insufficiency milk diet should be ordered. As a general rule an exclusively milk diet, indicated more particularly in pronounced hypertension with marked lesions of the heart and kidneys, is well borne, provided it be alternated with a lacto-vegetarian diet or an achloric meat diet. Constipation must be overcome by repeated purgation and, in addition, we must prescribe saline aperients, which constitute an active eliminatory medication in the same manner as sudorifics and diuretics.

When the spasmodic phenomena are complicated by sclerosis of the arterioles we must avoid all causes capable of provoking attacks of hypertension which may threaten the integrity of the fragile arterioles (emotions, physical strain, coitus, &c.). It is also important to bear in mind that drastic purgatives, such as jalap, should under these conditions be given cautiously, the patient keeping his bed for two or three hours after ingestion in order to avert any reflex of gastric origin or syncope due to cerebral anæmia.

In the treatment of permanent hypertension, antispasmodic and hypotensive treatment can at best only yield palliative results. It is indispensable to aim at the resolution of the sclerotic lesions, and with this object in view we may prescribe iodide of sodium *in small doses* (2 to 10 grains in the twenty-four hours), suspending the treatment from time to time and giving, in the intervals alkalies, intestinal disinfectants, and sulphate of soda, for the purpose of promoting the elimination of the iodide.

When the morbid process has reached the stage of arterio-sclerosis and atheroma, resolutive treatment, though useless in respect of the organic lesions, may still be of service in arresting, or promoting recovery from, the sclerotic lesions still going on in the small vessels of the new formation. But the most important thing under these conditions is to guard against the fragility of the arterioles and to avert hæmorrhage consequent upon rupture by obviating attacks of hypertension.

Before entering upon the discussion of syndromes with *hypotension*, it may be well to define exactly what we mean by this term. A pressure of 12 or 13 centimetres of mercury represents actual hypotension; from 10 to 11 marked hypotension; 8 to 9 well-marked hypotension, and 6 to 7 an extreme degree of hypotension. In pathological states the hypotension may be dependent upon a great variety of factors which may be classified as mechanical, nervous and toxi-infective. Among the mechanical causes we may mention copious or repeated hæmorrhage, exaggerated loss of liquid *per vias naturales* (copious diarrhœa, obstinate vomiting, profuse sweating, marked polyuria), pleural, and especially pericardial, effusions which hinder the pulmonary circulation, &c.

In regard to the action of the nervous system in the production of hypotension, a prominent part must be assigned to vaso-motor disturbances of nervous origin. In point of fact, among the nervous causes of hypotension, cerebral affections occupy a foremost place. Of all the causes of hypotension, the most important from the practitioner's point of view are those associated with toxic influences, the term intoxication being interpreted in its widest sense so as to include chemical, organic, autochthonous, and microbial poisons. Although a few rare microbial toxins may, under certain circumstances, raise arterial tension, the majority, on the contrary, lower the pressure, acting, though with more or less marked predilection, both on the cardiac muscle fibre, on the small vessels, and on the nervous system. The present state of our knowledge of hypotension in toxi-infective maladies is such that we must refrain from formulating precise conclusions in respect of prognosis and therapeusis. It follows that the hypotension usually observed in the course of typhoid fever must not be considered separately, but must be viewed in conjunction with other sources of information, more particularly the examination of the heart and the pulse. The fact remains that in many cases the practitioner will derive material assistance from observation of the radial tension even in regard to prognosis. Bearing in mind the usual tension curve in this disease—in which the hypotension is tolerably irregular (15 to 12) at the period of development, with a diminution coinciding with the defervescence (13 to 10) with irregular augmentations, we must be on our guard in presence of unduly pronounced oscillations which may foreshadow important complications. When, in the course of the disease, the more or less lowered tension suddenly rises to 17 or 18 cm., we are justified in apprehending intestinal hæmorrhage.

In variola the hypotension sets in early and attains its maximum at the stage of suppuration (Reynaud and Cotte). A hypotension of 11 cm. during the first day or two indicates a grave attack, and cases in which it falls to 9 or less almost invariably provefatal. In influenza the degree of hypotension is in direct proportion to the gravity of the infection. Drs. Jourdin and Fischer, more particularly in respect of the pulmonary form of the disease, observed that convalescence was protracted in proportion to the duration of the period of hypotension after subsidence of the fever. Pneumonia is likewise accompanied by hypotension. In mild cases the pressure hardly ever falls below 14, and returns to normal towards the twentieth day. In graver attacks it may fall to 10, and does not return to normal until the thirtieth day. In fatal cases it falls from the onset to 9 and less (Francois and Reynaud). It is, however, desirable to take the other local and general phenomena into account before committing oneself to a grave prognosis, even in presence of very pronounced hypotension.

In respect of pleurisy the tension is reduced only when the effusion is considerable in amount. Persistence of the hypotension after thoracentesis points to the probability of a recurrence. If the tension reached 18 or 20, kidney disease is to be apprehended. On the other hand, when it falls to from 14 to 11, the fact is suggestive of tuberculosis. In the last-named affection the hypotension assumes great importance, and may be observed before any other certain physical manifestation. This means that the existence of hypotension is capable of rendering great assistance in the differential diagnosis of tuberculosis and other morbid processes more or less resembling it, or of which it may simulate the appearances. We must nof forget, however, that in some tuberculous subjects the tension remains normal; indeed there may be slight hypertension.

From the point of view of therapeusis, hydrotherapy appears to be the most efficacious of the general measures having for object to re-establish arterial tension. The cold bath appears to be the most active, but the gradually cooled bath and wet packing act in the same way, though less energetically. The warm bath has a marked action on arterial tension, and it has been methodically employed in the treatment of hypotensive infectious diseases in children. This measure is specially indicated whenever the state of the heart, hæmorrhage or extreme youth constitute a contra-indication to the use of the cold bath.

Although hypotension is usually merely a symptom, and its special treatment forms part of the general treatment of the disease, there is one particular medication that is generally conceded to fulfil the rational treatment of this condition, in that it combats at one and the same time all the factors that contribute to bring it about—*viz.*, copious saline injections. In regard to adrenalin, its influence on arterial tension is extremely ephemeral, and its action exposes the patient to a whole category of accidents, consequently it should only be employed with great caution.

SOME NOTES ON FOOD AND FEEDING IN ALCOHOLISM.

By D. J. JONES, M.B., C.M.Edin.,
Deputy Coroner for South Brecknockshire.

Among the many problems which the physician is called upon to face from day to day, there is none more difficult and responsible than that presented by alcoholism, both in its acute and chronic forms. To deal with it at all effectually demands the readiest and ripest resources of his professional knowledge and experience. Not only must he understand alike the weakness and the strength of human nature, and possess a working acquaintance with all known drugs, but he must also take into consideration every detail of his patient's environment. Thus alone can he bring back to temperance and health the victim of the craving for strong drink, a habit that causes a vast proportion of the misery and crime with which our modern life is unduly weighted. In his efforts to deal with the individual the physician will gradually learn how to attack the great problem of national intemperance. It is only by prolonged and painstaking labour that he may one day hope to stay the monster that devastates society with the plagues of crime, disease, insanity, suicide, and racial degeneration.

It is trite to say that temperance reformers often injure their cause by inadequate knowledge of the subject of alcoholism. Nevertheless, that is the simple truth. It needs little acquaintance with their literature to show that for the most part they lack necessary information upon many important aspects of the failing against which their crusade is directed. Their one and only remedy for alcoholism is total abstention. For many reasons that method, however desirable upon abstract grounds, cannot be applied to individuals on any great scale. They fail to recognise that they are dealing with persons whose will power has been undermined and that without attention to such surroundings as food, exercise, and amusement teetotalism alone is in many instances foredoomed to complete and speedy failure.

Nevertheless, it must be confessed, on the other hand, that medical science has not hitherto supplied any full and adequate classification of alcoholism. That step must logically precede sound conclusions as to the causes and effects, to say nothing of the treatment of the craving for stimulants that seems to be inborn in mankind of all races and all climates, and, so far as that goes, of all time.

Without attempting to go into details it may be stated broadly that the ill effects of alcohol upon the human body are due mostly to its action: (1) As a direct nerve poison, in which capacity it impairs the moral and intellectual sense; (2) as a direct irritant of the liver, kidneys and other organs, which it gradually undermines and destroys; and (3) as an indirect cause of starvation of tissues.

The field thus mapped out is a large one, and it is proposed here to discuss the last-mentioned only, namely, the chronic malnutrition or starvation of body tissues due to alcoholic abuse. By "abuse" is meant not only the excessive drinking that ends in intoxication, but also the insidious form which has been happily described by an American author as "immoderate moderate drinking." In this case the victim never gets drunk, and would indignantly reject the suggestion that he was not absolutely temperate in his habits. Yet these "quiet" drinkers are those specially prone to disease of internal organs and to premature death. They are the bane of insurance societies, and fill our gaols, workhouses, and lunatic asylums. In almost all cases they are deaf to the appeals of the temperance reformers.

One symptom, common to all phases of alcoholism, is impaired appetite. This is due partly to the deranged stomach, and partly to the fact that alcohol is in many cases used as a substitute for food. Beyond a doubt the latter foolish practice enters largely into what is known as industrial or misery drinking, to overwork, bad air, insanitary workshops and dwelling-houses, and other defects of environment. To a less degree a similar substitution is involved in convivial or luxury drinking, when sherry and bitters or a whiskey "peg" takes the place of the sandwich and biscuit and the plain non-alcoholic drink which would be far better fitted to eke out the physiological income of the individual than mere alcohol. As everyone knows, the more a man drinks the less he eats. The man who has been in his cups overnight can eat no breakfast next morning, but he is generally ready to add fuel to fire and to substitute further alcohol in place of solid food. The "immoderate moderate" drinker and the chronic tippler eat little either at breakfast or at any other time. The solitary and rare exception is the man of originally strong constitution who lives an active open air life and who is able to eat well in spite of an excessive consumption of alcohol. Exceptions, however, here appear to prove the rule, for it seems impossible to avoid the conclusion that in all likelihood the liberal amount of food is the saving clause in his exceptional case. It is the good average nutrition of his tissues that keeps him alive, just as it is the lack of nutrition, otherwise chronic starvation, that destroys his less hardily constituted fellow-drinkers.

Food furnishes the key to the situation. It is of little use to bring rest and calm to the excited brain unless due provision be made at the same time for the proper nutrition of the nerve tissues. It is not generally recognised that an overtaxed and over-stimulated brain needs not only rest, but also free and sustained nourishment. To quiet the brain by sedatives and narcotics will not bring relief to the disordered cells, which, as a matter of fact, stand in need of feeding far more than of physic. Hence the wise physician does not neglect the lore of the invalid kitchen. When faced with a patient whose tale of chronic malnutrition is told in pale face and thin body, who eats and sleeps badly, who, in short, is half starved, he straightway proceeds to ring the changes upon a long list of viands, and jellies, soups, meat extracts, pre-digested foodstuffs, dainty concoctions of cream, sugar, cereals and fruit, oysters, delicate fish, marrow, sweetbreads, and what not, are pressed into his skilful service.

Modern science, let us hasten to say, has recently strengthened the physician's hand a hundredfold by the introduction of a new food, to wit, sanatogen, which has simply revolutionised the whole art of invalid feeding. The wonders brought about by this new preparation are no less manifold than amazing. They have been testified to by leading physicians whose names are as household words in many countries of the world. The substance is simplicity itself; it is of a floury nature, and is beaten up and taken with milk or cocoa in teaspoonful doses, or may be added to any kind of broth or bouillon or soup or beef-tea, or even to custard or arrowroot or gruel. It is readily absorbed by the stomach and has an immediate and remarkable effect, shown by a steady increase of body weight and of muscular strength and energy. Patients who have grown thin as the result of chronic maladies put on flesh at the rate of one or two pounds per week, or even more in some instances. At the same time the colour is brought back to the patient's cheeks. That this last-mentioned result is due to a specific increase of red blood corpuscles has been shown by repeated and skilled examination of the blood of persons going through a course of feeding by sanatogen.

Equally good results are met with by the administration of this new remedy in acute diseases attended by wasting and prostration. It stays the appetite in a way attainable by no other means in the hunger that usually marks the recovery stage of typhoid fever. Its feeding and sustaining properties are invaluable in the complete loss of appetite that often spells danger in attacks of influenza. To nourish the patient then becomes a matter of life or death, and under these circumstances the supreme importance of highly nutritive and absorbable food in small bulk is recognised. Much more might be written under this head did space allow. The only other point, however, that will be attended to here is the most recent and in many ways the most remarkable field of usefulness to which sanatogen has hitherto been applied—namely, in the treatment of acute and chronic alcoholism. There are obviously two ways in which it may act as a remedy—namely, as a curative and as a preventive remedy.

1. *As a Curative Agent.*—Attention was drawn to this point by a distinguished English physician who found remarkable results both in acute and chronic alcoholism. His experiences have been confirmed by other medical men, and it is not too much to say that a new chapter has been already added to the therapeutics of alcoholism. The explanation of the good results is probably simple enough. Sanatogen supplies the much-needed nutrition to the brain cells as well as the necessary fillip to heart, stomach, liver and other organs of the body. As a consequence the patient sleeps; his energy of mind and body is gradually restored and he takes exercise and gradually returns to his natural occupations and amusements. Last, but not least, his brain being in a healthier condition, he loses his depression of spirits and is afforded another chance of regaining self-control as regards his besetting evil habit. To sum up the position shortly: the balance of his nutrition has been restored, and with it his chances of recovery both for the time being and permanently have been many times multiplied.

The value of sanatogen in this condition is well illustrated by the following case recently published by Dr. Robert J. Carter:—

A married woman, æt. 36, had for many years given way to habits of intemperance. She was never distinctly intoxicated, but her general appearance indicated that she was imbibing far more alcohol than was either wise or necessary. She had lost most of her good looks, her face was always flushed, her hands were tremulous, she was unable to write even the simplest letter in the morning or the early hours of the day, and her temper was distinctly irritable. Her moral tone had deteriorated, and although in a good social position, she was seen on more than one occasion coming out of a low public house not a mile from her residence. She was catholic in her tastes with respect to drink, and usually commenced in the early morning with a pint of old ale, followed by a wineglass of green Chartreuse. Many attempts were made to reclaim, and for a time she was in a home for inebriates. There was an improvement, but it was soon followed by a relapse. A trip to Scotland, with plenty of outdoor exercise, improved her assimilative powers, but in no degree diminished the craving for alcohol. Large doses of perchloride of iron were given, but had no effect other than producing severe constipation. Sanatogen was then recommended, and agreed admirably. She was honestly anxious to get well, and the sanatogen apparently improved her will-power to such an extent that gradually she diminished her allowance of alcohol, and suddenly, to the astonishment of her family, became a staunch teetotaller. She has taken no stimulant for six months, and one is justified in hoping that her cure will be permanent.

The following is an equally instructive case:—

An officer in the Royal Navy contracted habits of intemperance which ultimately led to his retirement. On the China station he suffered from malaria and sunstroke. His family history was a bad one, many of his immediate relatives being alcoholic. He was readily affected by stimulants, a couple of glasses of whisky and water depriving him of all self-control. His bouts of intoxication were intermittent, but they were severe and of long duration. Whilst in this condition he was lost to all sense of decency. He was for six months in a retreat, spending most of his time in the open-air and devoting his attention to gardening and poultry-farming. He celebrated his discharge by drinking heavily for a week, until he was on the verge of delirium tremens. Hypnotic suggestion was then essayed but this too failed. A large sum was paid by his friends for a gold-cure treatment, but this proved worse than useless. Various drugs, such as atropine, injected hypodermically, red cinchona bark, capsicum, and other similar reputed remedies seemed only to increase his craving for drink. Finally, his medical adviser suggested a trial of Sanatogen. The morning vomiting from which for many months he had suffered ceased. His appetite improved, his face assumed a more healthy aspect, and at the expiration of a fortnight his red blood corpuscles had risen from 4,000,000 to 4,500,000 per cm.—a gain of half a million in a comparatively short time. The improvement in the condition of his blood was also indicated by the fact that the hæmoglobin had increased by 4½ per cent. This was a distinct inducement for continuing the treatment which was persevered in steadily. At the expiration of a month the craving for stimulants was much less marked and the condition of his blood, as shown by repeated tests and examinations, had still further improved. He has taken Sanatogen now for six months and since the first week he has had no outbreak. It would appear that in this case the Sanatogen acted not only as a food, but in virtue of the easily assimilable form of phosphorus which it contains, as a nervine tonic, supplying that stimulus to the higher centres of the brain and spinal cord necessary to overcome the habit of a life-time.

2. *As a Preventive Agent.*—Here, again, it is necessary to insist upon the fact that the terrible curse of drink craving, apart from mental unsoundness, is often a simple expression of overwork or of general malnutrition. It is clear that anyone who fails to take a sufficient amount of food must sooner or later induce a condition of anæmia. Nor is it less understandable that the anæmic person of either sex should turn to alcohol in the natural desire to stimulate a feeble heart. A more rational plan of treatment would seek a cardiac stimulus in food rather than in alcohol. As a matter of fact, the value of a carefully regulated and systematic dieting in the treatment of alcoholism has never yet been adequately recognised by medical authorities.

The following case illustrates the value of Sanatogen in incipient cases of alcoholism:—

A bank clerk, æt. 21, the son of a widow, gradually acquired the habit of taking alcohol to excess chiefly in the form of "nips" of whisky or of sherry or sherry and bitters in the morning or during the luncheon hour. There was no craving for stimulants in the ordinary sense of the word, but the young man was extremely anxious to obtain promotion, and, being of a delicate nervous constitution, fell into the belief that stimulants taken at frequent intervals would the better enable him to do his work. His failing was noticed by his superiors, and he was plainly told that unless there were a speedy improvement his position would be forfeited. He fully realised the gravity of the situation, but was unable of his own will to stop the habit. At his mother's request he determined to give sanatogen a six months' trial. It answered admirably, and he has abjured whisky and sherry and now takes only bitter ale, and that in moderate quantities at his mid-day meal and at supper.

It may be useful to conclude this article by a brief note on the main points to be attended to in the treatment of alcoholism.

1. Stop alcohol absolutely in acute cases; and, whenever possible, in confirmed and in immoderate moderate drinkers.
2. Remember that alcohol is a good servant but a bad master. It is not a necessity but a luxury of life.
3. Procure sleep and soothe the worn-out nerve centres.
4. Ensure the regular and effective action of the skin, liver, kidneys, and other organs of the body.
5. Place the patient under the most favourable conditions obtainable as to warmth, pure air, exercise, amusement and wholesome surroundings generally.
6. Attend above all things to the nutrition. Feed your patient systematically with sanatogen for months together. Remember that in all cases it acts as a powerful stimulant to the nervous system, exciting to more vigorous action the weakened will-power and affording the protection so necessary to resist the insidious effects of alcohol. It can do no harm, and opens up a prospect of permanent recovery. Such patients, however, are apt to be careless and untrustworthy, and it will, as a rule, be necessary to insist that the food is taken regularly and to accept no alternative excuses. At the same time it is desirable not to neglect careful treatment by drugs, which now and then are of incalculable service, although alone they are as a rule powerless either to prevent or cure alcoholism.

Little argument is needed to prove the unwisdom of lecturing an intemperate man while his brain is starved and simply shrivelling up for lack of nourishment. The logical course is first to feed his brain cells and then later try to instil the precepts of common sense. It is of little use, again, to give ordinary food to a man whose powers of digestion are certain to be more or less impaired by the use of stimulants. Sanatogen, on the other hand, is a perfectly ideal food for the purpose, inasmuch as it is readily absorbable, but also possesses nutritive qualities of the highest value. As an agent in the cure and prevention of all stages of alcoholism, so far as one can see, this new preparation constitutes one of the most powerful weapons ever placed in the hands of the medical profession.

THE PSYCHOLOGY OF THE INEBRIATE. (a)

By T. CLAYE SHAW, B.A., M.D., F.R.C.P
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The title of the paper suggests that the mental processes of the inebriate are defined and are induced, that they are *sui generis*, a kingdom with a debased coinage, at times difficult to tell from the ring of the true metal. The result of inebriety is a changed *ego*, which has its proprium of external and internal characteristics. If self-analysis is difficult, how much more so is it to penetrate the motives and feelings of conditions of which we have no experience. The purport of this introduction is to draw attention to the external manifestations of the inebriate mind; to enter reliably into the subjective condition would require the experience of an inebriate de Quincy to confess oneself a converted inebriate recognising even for such an one the difficulty of contrasting past with present states of feeling and of reviving memories which are already weakened by the prominence of new images. At the base of satiety is the strong feeling which we call a "craving." Life is full of "cravings," some leading to harmful indulgence, others simply to the degree of repletion necessary to maintain the due balance of metabolism, and just as there are physical, so are there psychical cravings. Factors in cravings are time, habit, and periodicity. Appetite is the index of a want in the system; it may be described as the *somatic index* for the normal body, whilst craving is that of the artificial or disordered one. Habit means that an artificial state has been set up, which can only be changed by the stoppage of the supply of material which feeds the changed conditions, just as on the mental side we must have an entire change of ideas to get rid of an obsession. Is this then the pathology of inebriety? Does it point to an altered physical state which requires its own particular mode of nutrition? If so, we must endeavour to appreciate that modification of tissue with its attendant feeling. At present this knowledge is impossible for us, inasmuch as we do not even know the nature of Feeling, nor of its association with other nervous processes. We do not even know whether when an individual can take enormous quantities of alcohol without visible impairment he owes his immunity to his stomach or to a particular composition of his nervous system.

(a) Abstract of paper opening a Discussion at The Society for the Study of Inebriety, Tuesday, July 11th, 1905, held in the Rooms of the Medical Society of London.

One of the chief objective features of the inebriate is *suspicion*, seemingly due to a condition of toxæmia setting up excitement of the peripheral nerves and particularly disorganising the muscular element of thought. The key to this condition is best explained by Dr. Bevan Lewis, and the theory is a very plausible one. It rests on the evolution dogma that what is last acquired and is the most voluntary in any conscious content is, in degeneration, the first to go. As a result of his devolution there is engendered a feeling of resistance and a disposition to attribute this to some person, ending eventually in a change of the *ego* which proceeds to develop the new individuality and to mould all things to the perfection of the new state.

From this point of view craving is not so much a question of sensuous indulgence as an urgent compulsion to supply a necessary food, the individual all the time having a positive loathing of the course he has to go through to acquire the end which becomes an irresistible and compelling force. Other features of the inebriate are mental restlessness and explosiveness, the co-ordinates of a wasted inhibition. The former is due to increase of subject-consciousness and loss of the sense of awareness leading to doubt and uncertainty in his social accommodation, and therefore to explosiveness in his sudden desperate efforts to right himself.

Wundt's elaborate theory that social environment is the ultimate cause of will, affords a corroboration of the above explanation of the impulsive condition of the inebriate. Emphasis is here placed on the motor side of the lesions in the inebriate, as shown in the paralytic form of speech, the tremors, the giddiness and the difficulty in orientation leading to the need of paying attention to the footsteps and hence to walking with the head downward and the eyes fixed on the feet. From these lesions spring agoraphobia, or the fear of walking across open spaces, shyness, self-seclusion, and lying (the latter to make excuses for his peculiar conduct and for his social offences), the reputation for laziness, for extravagance.

Secondary impairment of the heart and of the capillary circulation account for many of the social lâches of which the inebriate is guilty. Special notice was here drawn to the rise in sexuality and in religious demonstration in this class of persons and reasons for the new display given, the paper concluding with an explanation of the symptoms of moral degradation, and a plea for commiseration with this unfortunate class who are really the victims of disease, occasionally showing in their disordered flashes of memory the remains of former intellectual accomplishments which could only have been achieved by patient work and an originally artistic temperament.

Clinical Records.

LIVERPOOL NORTHERN HOSPITAL.

Case of Strangulated Hernia followed by Chronic Intestinal Obstruction from Adhesions.

Under the care of K. W. MONSARRAT, M.B., F.R.C.S.E.,
Surgeon, David Lewis Northern Hospital, Liverpool.

ON August 9th, a man, æt. 51, was admitted to the Northern Hospital, suffering from strangulated inguinal hernia. He had had a hernia for fourteen years, for which he had not worn a truss; of late years it had been about the size of his fist, and was always down. On Saturday night, August 8th, he had a sudden violent attack of pain, referred to the hypogastrium and the rupture; this continued during the night and the rupture became larger; he vomited frequently from the time the pain commenced until his admission to hospital on the evening of the following day.

On admission he was found to have a scrotal hernia, the size of a large cocoa-nut; the house-surgeon's notes say "a Rugby football," but this is rather an exaggeration; the scrotum was tense, tender to handling, bluish-purple in colour, and tympanitic to percussion. At the operation the contents of the hernial sac were found to be small intestine; the gut was intensely congested, but except for a greyish-purple patch on the entering coil at the neck of the sac, did not show evidence of marked damage; the peritoneal coat was intact over this patch, and resection was judged unnecessary. There were several feet of gut in the sac, and there was some difficulty in returning it to the abdomen.

There was an evacuation of the bowels on the day following operation, and no pyrexia for four days: after this he commenced an evening rise to about 100° to 101°, and complained of slight general abdominal pain. This continued for three weeks. The pyrexia was somewhat puzzling, as there were no physical signs to account for it, and all the man complained of were the vague general abdominal pains already alluded to. He was allowed up three weeks after the operation, and during the following week the pyrexia disappeared; he then commenced to define his abdominal pain as restricted to the right iliac region, and constipation became troublesome. The right iliac pain persisted; on palpation here there was local tenderness, but no other abnormal physical sign. On October 14th I opened the abdomen in this region and found a mass of intestinal coils, matted together by adhesions, and bound down to the parietal peritoneum;

the affected small bowel formed a complicated coiled mass, and there was distinct compression by adhesion at one particular point, above which the bowel was somewhat distended, while below it was comparatively collapsed. After freeing the adhesions and suturing the omentum in one or two places to cover the raw surfaces thus left, I closed the abdomen. This operation was followed by entire disappearance of the constipation, local pain, and local tenderness, and the patient was discharged from hospital on November 20th. The condition was therefore one of local plastic peritonitis following damage to the gut by strangulation, resulting in the formation of firm adhesions which so matted together the affected section of the gut that intestinal obstruction was caused thereby.

This complication following strangulation is one which is of course recognised as occurring in a small proportion of cases. No doubt local peritonitis occurs to a greater or lesser degree in all strangulated herniæ, except perhaps those which are very early relieved; it is exceptional for it to proceed to the formation of the tough adhesions which were found in this case. I am not aware that this complication can be foreseen, except in so far as the degree of damage caused to the gut points to the probability of considerable local inflammatory reaction. It indicates that simple mobility is not the only point to be considered when deciding whether a portion of gut is to be returned to the abdomen; in other recorded cases this post-operative obstruction from adhesions has ended fatally. It is useless to be dogmatic as to the circumstances under which resection of gut is a wise proceeding; every case is a problem in itself, particularly in regard to the advisability of subjecting the patient to a prolongation of the operation. Where the general condition is good, the indications for reaction are extended; where the general condition is bad, as in this case, more risks must be taken, and the case illustrates one of several which should be borne in mind.

Transactions of Societies.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

The annual Provincial Meeting was held on June 17th at the Hospital for Children, Sheffield, Dr. C. H. Willey in the chair.

Dr. C. N. Gwynne showed cases of congenital dislocation of the hip, congenital dilatation of the colon; multiple tuberculous foci, infantile paralysis of the leg treated by arthrodesis, calcaneo-valgus treated by arthrodesis, excision of the knee for tuberculous disease, and (?) Hodgkin's disease.

Dr. Willey showed a case of pseudo-hypertrophic paralysis.

Dr. J. H. Wilks showed five cases of congenital dislocation of the hip; strangulated hernia in a baby two weeks old, successfully treated by operation; paralysis of tne 3rd, 6th and 7th nerves; a huge nævus which had recovered without treatment; and a case of congenital pulmonary stenosis.

Mr. Simeon Snell showed cases of blindness from congenital defects.

Mr. S. E. Morton showed cases of malformation of the spine and side; malformation of the hand; Dupuytren's contraction of the hand; and enlargement of the liver.

Dr. H. Leader showed three cases of Erb's paralysis, and one of splenic enlargement.

An extremely interesting and beautifully prepared series of pathological specimens was exhibited by Professor Arthur Hall to illustrate (1) hydrocephalus; (2) tuberculous tumours of the brain and cerebellum; (3) abscesses of the brain; (4) meningitis; (5) granular kidneys; (6) Hodgkin's disease; (7) meningocele; and (8) cirrhosis of the liver.

Other specimens shown were:—Congenital obliteration of the bile ducts, by Dr. J. G. Emanuel; imperforate anus, by Dr. Wilks; and the kidneys and mediastinal growth from a case of lympho-sarcoma by Dr. Leader.

Dr. Gwynne read a paper on a case of

OSTEOMYELITIS AND SUPPURATIVE PERICARDITIS

in a girl, æt. 7, successfully treated by operation in 1903. The osteomyelitis affected the femur and radius. Incisions were made. Parotitis and pericarditis followed in three days. The pericardium was laid open ten days later, giving exit to about ten ounces of pus. A tube was inserted and removed on the tenth day. Further pyæmic complications ensued, but the child ultimately recovered. The apex of the heart was now about half an inch inside the nipple line, in the sixth space.

Dr. G. Carpenter and Mr. S. Stephenson reported a case of

TUBERCLE OF THE CHOROID,

with certain peculiarities, in a girl, æt. 3. A very large number of fawn-coloured tubercles, in size up to that of the disc, were found almost exclusively near the optic disc. A diagnosis of acute miliary tuberculosis was made. Death resulted thirty-three days after the onset of the illness, nineteen days after admission, and five days after the diagnosis was made. Apart from the eyes the condition could not have been diagnosed with certainty during life. The peculiarities were the number and size of the tubercles, and the invasion of the retina by the tubercles.

Mr. J. Jackson Clarke drew attention to some practical points in the

TREATMENT OF CONGENITAL DISLOCATION OF THE HIP

by Lorenz' method. Under anæsthesia the shortened muscles, viz., adductors, hamstrings, ilio-psoas and rectus femoris must be fully stretched. In children over four years of age the adductors may require division by subcutaneous tenotomy. The great trochanter must be brought down to, or below, its normal level. He then described the act of reduction, the mode of application of the first retention apparatus, the subsequent use of massage and exercises, and the management of special cases.

Mr. R. C. Dun described a case of median hare-lip, a very rare deformity. The cleft was exactly in the middle line, the incisor teeth perfect, and there was no alveolar cleft.

Mr. H. S. Clogg read a paper on

APPENDICITIS IN A HERNIAL SAC,

based on the cases of two boys, æt. 3 and 8, successfully treated by operation. He estimated that 25 per cent. of recorded cases occurred in children, and mentioned that it had been reported in quite young infants. He stated that the appendix in a hernial sac was unusually prone to inflammation; that the condition could not be differentiated from strangulation of the appendix or of Meckel's diverticulum; that most cases were mistaken for strangulated hernia because of the sudden onset, abdominal pain and the presence of a local irreducible swelling, without impulse on cough. The presence of fever from the onset, the indefinite character of the swelling, and its small size, and the early occurrence of œdema and redness of the skin were of diagnostic value.

Dr. Gwynne read a paper on two cases of multiplex xanthoma; Dr. Wilks, on a case of sudden death after needle puncture for supposed empyema, with specimen; Mr. A. H. Tubby, on osteomyelitis of the spinal column; and Dr. Leader on a case of Hodgkin's Disease.

ULSTER MEDICAL SOCIETY.

The annual meeting of this Society was held in the Medical Institute, Belfast, on Thursday, June 29th. In the absence of the President, Dr. Calwell, the chair was taken by the ex-President, Dr. John Campbell.

The annual report was read by the hon. sec., Dr. T. Houston. It showed some falling off in the membership during the year, chiefly among country members. The total loss of members from all causes was twenty-one, while ten new had been elected. The members lost by death were Dr. W. A. McKeown, Dr. Owen Praeger, and Dr. John McClatchy. The Council reported, with regret, that the hon. treasurer Dr. W. B. McQuitty, and the hon. librarian, Dr. R. R, Leathem, had resigned their posts. The Council recommended the appointment of an editorial secretary to attend to the collection of papers and their publication in the Transactions, and also recommended some minor alterations in the rules. The adoption of the report was moved by the hon. sec., seconded by Dr. Kevin, and passed. The statement of accounts was read by the hon. treasurer, and showed a balance at the beginning of the financial year of £153, and at the end of it, £155, the subscriptions of fellows and members amounting to £280 7s.

The hon. librarian's report was read by Dr. Houston, in the absence of Dr. Leathem, and adopted.

Sir William Whitla moved, and Professor Lindsay seconded, that the best thanks of the Society be accorded to Dr. McQuitty and Dr. Leathem for their long and valuable services to the Society in the offices of hon. treasurer and hon. librarian respectively. This was passed by acclamation.

Professor Byers called attention to the death—just taken place—of an old member and ex-president of the Society, Dr. G. F. Wales. Though long retired from active practice, many of the senior members of the Society could remember him well in his active days, when his advice was much valued and sought after by his professional brethren. Professor Byers moved that the hon. secretary be instructed to convey to the surviving members of the family the sympathy of the Society in their bereavement. This was seconded by Dr. Dempsey, and passed.

The following were elected office-bearers for the next session:—President—Dr. Wm. Calwell (second year of office). Vice-Presidents—Dr. J. C. Martin (Portrush), and Dr. J. R. Davison. Hon. Secretary—Dr. Thos. Houston. Hon. Treasurer—Dr. Victor Fielden. Hon. Librarian—Dr. W. L. Storey. Hon. Editorial Secretary—Dr. Howard Stevenson. Council—Drs. D. P. Gaussen (Dunmurry), Robt. Hall, John Morrow, W. B. McQuitty, R. C. McCullough, and D. McKinney, together with the seven trustees, Drs. John Campbell, Dempsey, Lindsay, McCaw, Mitchell, Nelson and Cecil Shaw.

Dr. McQuitty showed a case for diagnosis, a man whom he had just seen in the Royal Victoria Hospital. The patient was a man of about 55, with nothing of note in his family or personal history, till the last year when he had suffered from several attacks like the present one, though not so severe. Each attack began with a feeling of burning and tingling in the stomach, which soon spread up to the throat, rendering swallowing difficult. These sensations spread in a few days to the arms, hands, legs and feet, always in the same order, and following the tingling and burning came a copious rash, which ended in free desquamation, such as might be seen after a smart attack of scarlatina. The hands were peeling freely when the patient was shown. There was no temperature or general disturbance, and all the organs were found normal. Dr. McQuitty said that the case was, to him, quite unique, and he could find no record of a similar one.

NORTH EAST LONDON CLINICAL SOCIETY.

The Annual General Meeting of this Society was held at the Tottenham Hospital, N., on Thursday, July 6th, 1905, the President, Dr. R. Murray Leslie, in the Chair.

The Council reported that the past Session was noticeable for the excellence of the material presented at the Clinical Meetings, which has led to a very considerable increase in the average attendance of members. The following gentlemen were elected as officers for the ensuing Session, 1905-6:—*President*, Dr. C- E. Hutt; *Vice-Presidents*, Drs. G. P. Chappel, F. H. Daly, J. W. Hunt, R. M. Leslie, G. N. Meachen, F. J. Tresilian, and Messrs. W. Edmunds, and R. F. Tomlin. *Council*, Drs. J. Beddow, H. Corner, R. E. Foott, A. E. Lermitte, E. H. May, E. F. Willoughby, and Messrs. R. P. Brooks, W. H. Paine, A. de Prenderville, T. Rushbrooke, C. R. Salisbury, A. S. R. Wainwright. *Hon. Treasurer*, A. E. Giles; *Hon. Librarian*, A. J. Whiting; *Hon. Secretaries*, H. W. Carson and G. P. Chappel.

A garden party was afterwards held in the grounds of the hospital, which was largely attended by the members and guests, including ladies.

The annual dinner of the Society was also held on Friday evening, July 7th, at the Abercorn Rooms, which was well attended, a capital musical programme being provided.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, July 9th, 1905.

Pityriasis Versicolor.

The treatment of pityriasis versicolor can be abandoned to the fancy of the physician as to the choice of antiseptic solutions. It is thus that the number of parasitic remedies is considerable. While some prefer a solution of perchloride of mercury, others are content with carbolic soap, iodine or ointment of eucalyptus or creosote. One of the best and cleanest remedies, however, is the following:—

Borate of soda, 1 drachm;
Oxygen water (12 vol.), 6 oz.;
to be rubbed on the parts night and morning.

Gout.

Iodide of lithium, 1 grain;
Extract of gentian, q.s.;
for one pill three or four daily; or—
Iodide of lithium, 1½ drachms;
Syrup of bitter orange, 7 ounces;
two or three tablespoonfuls a day; or, if chronic nephritis be present—
Extract of stigmata maydis, 1½ drachms;
Benzoate of soda, 1 drachm;
Carbonate of lithium, 1 drachm;
Oil of aniseed, 3 minims;
divide into 60 pills, two at each meal for twenty days a month, and continue three years.

Hæmorrhoids.

Chrysarobine, 15 grains;
Iodoform, 9 grains;
Extract of belladonna, 10 grains;
Vaseline, 5 drachms;
externally.
Chrysarobine, 1 grain;
Iodoform, 3 grains;
Extract of belladonna, ⅛ grain;
Cacao butter, ½ drachm;
for one suppository.

Pruritus of the Anus.

Bichloride of mercury, ½ grain;
Hydrochlorate of ammonia, 3 grains;
Phenic acid, 1 drachm;
Glycerine, 2 ounces;
Rose water, 5 ounces;
to be applied night and morning.
Hydrochlorate of cocaine, ½ grain;
Cacao butter, q.s.,;
for one suppository.

Antiseptic Ointment.

Antipyrin, 1 drachm;
Salol, ½ drachm;
Boric acid, ½ drachm;
Iodoform, 15 grains;
Phenic acid, 15 grains;
Corrosive sublimate, 2 grains;
Vaseline, 7 ounces;
for general use (Réclus).

Cerebro-Spinal Meningitis.

Iodide of potassium or sodium have been tried in the recent epidemic of cerebro-spinal meningitis with negative results. M. Ruheman publishes a successful case treated by iodate of soda. A boy of 13 was in a hopeless condition, but made a rapid cure under the influence of the following treatment:—

Iodate of soda, ½ drachm
Water, 4 ounces;
half a tablespoonful two or three times a day.

The same author recommends subcutaneous injections of the iodate as near the head as possible (back of neck, shoulders)—

Iodate of soda, 15 grains;
Eucaine, 6 grains;
Distilled water, 5 drachms;

one or two syringes morning and evening.

Germany.

[From our own Correspondent.]

Berlin, July 9th, 1905.

At the Surgical Congress, Hr. Garré, of Königsberg, spoke on the

Suture of Wounds of the Lungs.

He said that surgeons were very backward in suturing large wounds in the lungs when threatening symptoms were present from hæmorrhage. The mortality in such injuries was very high; statistics of over 700 cases showed a mortality of over 70 per cent., and if only the more serious cases were included it would be much higher still. If the present results were compared with those of pre-antiseptic time no essential advance could be shown, as patients still died first from internal hæmorrhage, secondly from thoracic tension, and thirdly wound infection, as the internal wound was not treated at all, or only when it was too late, and when pleurisy and the further sequences had already set in. The speaker first addressed himself to internal hæmorrhage which was an urgent indication for operation, especially if Lauerbach's apparatus was at hand, or when Brauer's own pressure process could be made use of. But even if these aids were not forthcoming, there was no contra-indication of operation, as the lung was already collapsed from the wound made in it, so that fresh symptoms of collapse need not be feared from operative procedures; on the contrary the breathing would be much easier from the drawing in of the lung in the wound of the thorax, whereby the lung was shut off from the outer air. The speaker mentioned a case of subcutaneous rupture of the lung that was brought into hospital the third day after the accident, the patient being in a condition of great distress from dyspnœa. After drawing the lung forward the breathing was much easier. A boy, æt. 11, was brought in in a state of cyanosis and a pulse of 132 to 140. There was extensive hæmopneumothorax on the left side. The thorax was at once punctured, but without any improvement. Thoracotomy was then performed, the lung was drawn forwards and a rent was found 5 cm. in length and 3 in depth, which was closed by five sutures. After this the lung regained its size quickly. Death took place in two days it is true, but the indications were not the less valid, considering the fortunate results that have been obtained in other cases. Eight cases of the kind were recorded in the literature of the subject, with six successful results, following suture of the lung. He proposed thoractomy and suture of the lung, only in cases of serious memorrhage into the thorax, and in cases of repeated hæmorrhage and where tension was not relieved by puncture alone.

As regarded technique he had practised on animals. One should not be afraid of narcosis, the wound should be free, in order to be able to draw out the lung easily. In case of internal hæmorrhage it was best to get in laterally, in external hæmorrhage from the wound itself. The collapsed lung was then drawn into the wound by forceps, the injured part being next sought for, and after careful cleansing the sutures were to be inserted, and to prevent them tearing out, not too near the edge of the wound. Silk sutures were the best. Wounds near the hilus could only be tamponaded, extensive bruised wounds should be brought outside.

In answer to a question as to the treatment of the pleural cavity he said he packed lightly and only closed definitely when there was subcutaneous hæmorrhage; the open treatment gave the best results. He would perhaps put in a deep drain in case of infection.

Hr. Rehn recommended the preliminary shutting off of the pleural cavity, as the breathing would be rendered very much easier by it, if we were compelled to open later on.

Hr. König shut the pleural cavity off if there were grave symptoms of pressure change. In general it was not so dangerous to work in the thoracic cavity without Lauerbach's apparatus which cost about £800 (16,000 m.). According to experiments he had made, animals were very little affected by wounds of the thorax and lungs. He had observed the same thing in about a dozen men. He had only seen one fatal case from unilateral injury to the lung. But he would not go into the lung without urgent cause such as a foreign body, even without suture adhesion and closure took place rapidly, and a wound in the lungs was fatal only when a large vessel was injured, and when a large bronchial branch was cut through, out of which such a large quantity of air escaped and with so much force that closure by suture was not possible.

Hr. Garré observed that infection was much more dangerous in the human subject than in animals. These dangers were avoided by operation. A large bronchial branch might be closed by suture, but the edge of the wound must be freshened and a double suture applied.

At the Medical Society Hr. Ewald showed a patient with

Extreme Stenosis of the Œsophagus

from drinking lye in mistake for white beer. When he first saw the patient a fortnight ago she was very much reduced; the stenosed part could not be passed with the finest sound. By means of the œsophagoscope the gullet could be seen to be firmly closed by a bright red membrane. As the patient could still swallow liquid in small quantities, there must be a small passage left, and for this reason the speaker persevered day after day trying to find it. Finally on the twelfth day he did succeed in discovering it under the guidance of the œsophageal tube. He was now able to pass a whalebone sound 3 to 4 millimetres in diameter, when the head was bent forwards, so as to put the œsophagus on the stretch. All soft sounds were unreliable as they bent too easily.

Hr. Mosse showed two females with

Vasomotor Trophic Neuroses.

The first, a woman, æt. 41, after lying ill in bed a long time noticed coldness and pain of the fingers. They were not enlarged, but cold and blue, and the sensibility was not disturbed. There was bilateral catarrh of the apices, no anomaly of the nervous system. The symptoms had remained unchanged a long time.

The second case was that of a woman, æt. 39, who, after being delivered of a still-born decomposing fœtus showed hyperæmic thickened patches about mouth, eyes, nose, and chest; the hands were thickened the skin rough and cold. The bones in the right hand were seen by Röntgen light to be atrophied; there was painless œdema of various joints, no disturbance of sensations. The case was diagnosed as one of scleroderma.

Examination of the blood showed fewer erythrocytes in that taken from the fingers than in that from the lobe of the ear. This was the case in both patients.

Austria.

[From our own Correspondent.]

Vienna, July 9th, 1905.

Anti-Pyrene Exanthemata.

Loebl showed a patient, æt. 34, who had from time to time suffered from severe affections of the mouth, accompanied by an exanthematous rash. The last attack commenced on the first of the month, about three in the afternoon, which was carefully observed in order to determine the cause. The first subjective symptoms were a feeling of paralysis of the tongue, prickling and itching of the lips, cheeks, and tongue itself; two hours later the tongue was greatly swollen, making articulation difficult. About seven o'clock, or four hours after the onset, transparent vesicles, ranging from the size of fine shot to that of a bean. In many places they were confluent, and after the clear fluid exuded a tender sore was left. Three days later two large blisters rose on the hard palate, while other smaller ones were observed on the lips and inside of the buccal cavity, all covered with a deposit like plaques muqueuses. The smaller number were on the gingiva. The temperature was 39° C., 102·0 F., with a retrogression in the pathology from the first.

The diagnosis was easily recognised as stomatitis ulcerosa, but the etiology was more difficult to determine. Dermatologists had been consulted on former attacks, who advised her to consult a dentist about her teeth, which were repaired and removed, according to his judgment without any appreciable benefit. There was no taint of scorbutus to be suspected; nothing except the taking of antipyrin. On the second day of the illness, it may be mentioned, the patient had a feeling of creeping and itching in the lower limbs, leaving blisters after these had passed away; the back of the hands had at the same time a dark blue colour which extended down to the finger-ends with considerable œdema. This disappeared the following day, leaving a blister 3 by 1½ centimetres long on the left arm. These symptoms disposed of a local cause which demanded wider investigation.

Closer inquiry elicited from the patient that she had been taking powders for headache. At one o'clock, *i.e.*, two hours before the first phenomenon is recorded, she had taken one of these powders for her headache, which consisted of 0·2 gramme of phenacetin, and 0·8 of migrānin; the latter is a compound of antipyrin, caffeine, and citrate, containing 80 per cent. of the former, or 6·4 gramme of antipyrin or 9·876 grains per dose. She confessed that the former attacks came on after taking the powders, but gave it no more thought. Treatment consisted of a gargle of hydrogen peroxide and insufflations of anæsthesinorthoform, and avoid antipyrin in future by substituting maretin, which is more reliable for headache.

Anæmia Splenica.

Bleier presented a female to the society with splenic anæmia, who at one period of the disease had all the symptoms of pernicious anæmia, with confirmatory blood-tests.

In May, 1904, she came to Mannaberg's clinic complaining of extreme weakness, vertigo, exhaustion, and palpitation which had gone on during the four previous months.

The examination confirmed the external appearance of anæmia gravis, the liver slightly enlarged, while the spleen was enormous. The blood with Feischel's hæmometer was 18 to 20 per cent.; number of red blood corpuscles was 890,000; colour index, 1; and the number of white blood corpuscles, 5,100. When coloured the dry preparations revealed poikilo cystosis, with microcysts, numerous macrocysts, and nucleated red blood corpuscles forming a sort of normoblasts; but no megaloblasts were present.

The white corpuscles, for some reason or other, had 40 per cent. of lymphocytes, probably at the cost of neutrophile-nucleo-polymorphic cells, which were 53 per cent., while the eosinophile were 3 per cent., transitional 2 per cent., and mastocells, 2 per cent. No myelocys were present.

During her two months' residence in hospital the first half was almost negative. Gradually in the second half she began to improve, but rapidly at the end. After the sixth week the megalocyst was not to be found; poikilocysts less, with very few normoblasts. The percentage of lymphocytes fell to 42. Hæmoglobin 42 per cent., erythroscyte 2,800,000, and colour index 1. Along with this improvement, general strength, and vigour returned, and a month later was able to accomplish her former duties with comfort.

The blood examination now gives a steady return of hæmoglobin, 50 to 60 per cent.; red corpuscles, 3,500,000 to 4,000,000; while the leucocytes range from 7,000 to 9,000. The last special examination gave polynuclear cells, 80 per cent.; eosinophil, 2 per cent.; transitional, 2 per cent.; mask-cells, 2 per cent.; and 14 per cent. of lymphocytes. The liver by this time had assumed its normal proportions.

Schur thought these cases were of immense interest to the clinical observer, as they stood on the border-line of malignant and non-malignant. He related the history of a similar case that came under his own observation which had been diagnosed as pernicious anæmia, with every hæmatic proof present, yet the patient recovered as in the above case. It clearly proves that splenic enlargement, lymphocytosis, macrocystic anæmia, and all the other symptoms of that fatal disease may be present and yet prove innocent.

Ichthyosis Congenita.

Riehl next showed a female child, æt. 1½, enveloped in a case of ichthyosis from birth, which, he remarked, was still alive. The peculiarity of the case was the absence of any real cause. This was the second child of healthy parents, the first being healthy and perfectly normal; neither was there consanguinity. The little patient was stunted in development, appearing like a child of one year, although bright and happy in all its movements, and healthy otherwise, except the skin. The head was quite encased in a thin horny covering, with tufts of hair penetrating it at frequent intervals. Both ears were embedded in folds of the horny mass, and fixed to the side of the head. The upper lids of the eyes were imperfectly developed, while the lower were short and ectropion in appearance, standing far out from the bulb, with the conjunctivæ red and inflamed. The whole trunk is bound up as a warrior in a coat of mail, varying in thickness from 1 to 2 millimetres. The arms and legs were similarly covered, but thicker at the joints. It might be noted that the lower part of the trunk, and particularly the genitals, were free from keratosis, as well as the point of the nose, alæ, and lips, which were normal.

Newman said the case was of special interest from it living so long. Children with keratosis universalis are either still-born, or die shortly after birth. All these cases assume the same appearance of thickening of the epidermis, deep fissures, from respiratory movements, or intra-uterine flexures. The cases usually observed are insular and not universal, as in this case.

Operating Theatres.

NORTH-WEST LONDON HOSPITAL.

Cholecystotomy.—Mr. **Mayo Collier** operated on a woman, æt. 52, who had been admitted under his colleague, Dr. Harry Campbell, the senior physician, suffering from well-marked jaundice with considerable enlargement of the abdomen. The past history of the case was that the patient had been apparently before this seizure free from all serious illnesses. She had not suffered previous attacks of jaundice nor was there a history of biliary colic. The present illness dated back six weeks, when she noticed that she became jaundiced and that her abdomen began to get larger and continued to do so up to the date of her entering the hospital. On admission, the patient was intensely jaundiced, the motions were seemingly free from bile, but the urine was of a very dark colour. There was no sickness, no elevation of temperature, and the woman retained a moderate appetite. The chest cavity was apparently free from disease; the abdomen was much enlarged, but free from ascites and contained a well-marked enlargement in the right and upper half. On inspiration, the mass was evidently large, and it moved upwards with expiration. The lower limit of the swelling approached the iliac fossa, and here a distinct elastic cyst-like mass could be felt. Mr. Collier considered that this case was with little doubt one of enlarged gall-bladder, probably due to impaction of a calculus in the common duct, and with the consent of his colleague he decided to open the abdomen, and if, as he had expressed his opinion, the gall-bladder was enlarged from its outlet being occluded by a calculus, to cut down and remove the obstruction if possible. An incision was made on the outer border of the rectus a little below the umbilicus; on the abdominal cavity being opened the liver was found to extend some two inches below the umbilicus, and the gall-bladder some four inches below this. The gall-bladder was enormously distended, being the size of a small cocoa-nut. The peritoneum was free from adhesions and inflammation, and there was no fluid in the peritoneal cavity. Mr. Collier, having tapped the enlarged gall-bladder with a trochar and withdrawn over half a pint of bile, stitched the gall-bladder to the wound on a level with the umbilicus, the liver having in the meanwhile receded sufficiently to allow of this higher approximation. The gall-bladder was opened and was found to contain a large number of gall-stones; these were removed, 76 in number. Mr. Collier endeavoured to introduce a long bullet probe into the common duct, and in doing so came across apparently no obstruction. The finger was next introduced and the whole of the tissues in the region of the middle portion of the duodenum were explored, but no stone or cause for the obstruction was ascertained. The wound having previously been closed, a fair-sized drainage tube was inserted into the opening in the gall-bladder, and the patient returned to bed. Mr. Collier said that this case was apparently one of simple obstruction of the gall-bladder by the impaction of gall-stones. The history, the absence of pain, the short duration and suddenness of the illness, all, he thought, pointed in this direction. Enormous distension of the liver and gall-bladder was, he considered, consistent with a sudden complete obstruction of the common duct. The up to this excellent health of the patient and her freedom from pain negatived, he remarked, the suggestion of obstruction from malignant disease. The removal of 76 gall stones to some extent, he thought, bore out the diagnosis, but the fact that no stone had been found impacted in the common duct left a doubt in his mind as to the correctness of the diagnosis; on this ground Mr. Collier decided not to close the gall-bladder, and drop it in the peritoneal cavity, as by doing so the patient might have been left in exactly the same position as before the operation. By sewing the gall-bladder to the abdominal wound the patient, he pointed out, though not left in so satisfactory a condition as if the gall-bladder had been dropped into the peritoneal cavity, would be, so far as the distension of the gall-bladder was concerned, relieved of this and have a better chance of getting rid of the obstruction, whatever it might be.

The subsequent history of the case bore out entirely Mr. Collier's fears and anticipations. For the first ten days pints of bile continued to pour from the opening; the jaundice was not in the least relieved, nor did bile appear in the motions. The tube was removed and the opening allowed somewhat to contract; at the same time some pressure was exercised on it to induce if possible the bile to take its normal route into the intestine. This procedure was not followed by success, and no bile appeared in the motions. The patient steadily lost ground, all appetite ceased, and vomiting supervened; so there is but little doubt that some other cause exists for the obstructed common duct than a gall stone. Mr. Collier therefore proposes as soon as possible to have the patient anæsthetised and endeavour to make out the real cause of the obstruction.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 12, 1905.

THE REPORT OF THE IMPERIAL CANCER RESEARCH FUND.

The Report of the Imperial Cancer Research Fund comes at an opportune moment. The times are agog with curiosity as to the innermost secrets of disease, and that too in the street no less than in the laboratory and the lecture-room. Recently London has been invaded by a Parisian surgeon with a much-boomed "cure" for cancer. Although his claims have been before the scientific world for some time they have not hitherto received any but scant and hesitating acceptance. That fact alone would make any experienced medical man extremely chary in sanctioning the trial of so dubious a method. When, however, we find it imported into London and its alleged virtues advertised to the world in six or eight different languages, a flavour of commercialism is added to the matter which is both nauseous and degrading. British surgeons, we are happy to believe, are competent to treat sufferers from cancer by all approved methods with as much confidence and success as can be hoped for in the present stage of scientific knowledge. It is hardly to be imagined that under any conceivable circumstance one of our countrymen would seek to establish a kind of branch practice in Paris for the exploitation of a vague, theoretical, and absolutely nebulous "cure" of an incurable disease. The attitude of the British scientific medical world can be well gauged from the Report to which allusion has been already made. The recent work of the Research Committee has been directed to the logical essential of the discovery of elementary facts of causation. The part of the Report to which medical men interested in the subject will at once turn is that which describes certain biological and pathological investigations under the heading of "The growth of cancer under natural and experimental conditions." The results obtained by studying the disease in this way modify previous views to a considerable extent, while at the same time they control immediate inferences. "Cancer has been shown," runs one passage in the Report, "to be an identical process in all vertebrates, and to develop at a time which conforms in a striking manner to the limits imposed by the long or short compass of life in different animals. Cancerous tissue can be artificially propagated in the short-lived mouse by actual transference to another individual, but only to one of the same species, notwithstanding the histological identity in the nature of the disease in different species." Cancerous tissue thus propagated presents all the characteristic features of the malignant growth of sporadic humours; to wit, it infiltrates and produces extensive secondary growths. It is to be noted that experimental methods do not bear directly on the origin of cancer, although they throw a flood of light upon other aspects of malignant new growths. The most extraordinary fact of the experimental comparative growth is the continuous proliferation of the transplanted cells, which give rise to an undefined, enormous, and apparently limitless neoplasm. Under artificial propagation cancer maintains all the characters of the original tumours of the primary hosts. The statement of the Report is that the balance of evidence appears to be in favour of this enormous limitless growth being a cyclical form of proliferation, which is frequently renewed, and that in the first instanceit is added to the terminal phases of normal proliferation in different tissues. Many important and often obscure special problems are discussed in the Report. The discrepancy between the recorded cancer death-rate in Ireland and in Great Britain is fully entered into, with the general conclusion that the discrepancy is apparent rather than real. An important point is raised by the specimens of malignant new growths obtained through the Colonial Office from the natives of regions of Africa where cancer had not previously been discovered. Going back for the moment to the artificial propagation, we find that it establishes the fact that transmission is fundamentally different from all known processes of infection. The whole Report furnishes an immense amount of valuable material accurately collected and collated. It is a scientific document of the highest value, worthy of the humane spirit that prompted the organisation of the Fund, no less than of the patience and insight and self-effacement that characterises the highest efforts of modern scientific medicine. In its simplicity, its dignity, and its absolute candour it offers a striking rebuke to the seeking after notoriety and worldly gain that fix on certain atter- day scientists a brand of indelible reproach.

JAPANESE LESSONS.

There can be no need for apology if we refer again to some of the many lessons that Japan is teaching Europe, nor will there be, till it is plain that those lessons are being seriously laid to heart. Japan at the moment represents the spirit of modernity incarnated in a nation; a nation, moreover, which has definitely shaken off from the past everything but the driving power derivable from an intense sense of corporate duty. A nation thus equipped will be satisfied with nothing short of the best, and whether it be in war, administration, or science, Japan has not fallen short of the ideals its lynx-eyed statesmen of the seventies set before the people. The best-conceived plans may fail through over-reaching, unless they be carried out not only by a single-minded executive, but with a minute and painstaking attention to detail. Served as Japan has been by a galaxy of individual talent such as is only produced at times of national renaissance, the success that has so far attended her efforts has been due in a peculiar degree to the practical realisation of the value of initiative. The more that the present state of Japan is looked into, the more striking does this fact appear. The medical profession naturally turns to the condition of scientific and medical matters in seeking to assess the achievements and prospects of a country, and in no respect could a happier choice be made in the formation of an estimate of the Japan of to-day. In the elementary schools the natural sciences are depended upon as the instrument of mental training, so that every lad and girl in the country grows up with a mind trained to observe and reflect and possesses in addition a more or less intimate acquaintance with, and respect for, natural phenomena as guides to action. This scientific habit of mind is of priceless value in the cultivation of self-reliance and sound judgment, and it is a boon that Huxley was never tired of advocating as the birthright of every modern English child. As that great educationalist consistently maintained, natural science is natural knowledge, and as such should be placed before all academic acquirements in an educational programme, after the three means of obtaining knowledge—reading, writing, and cyphering—have been acquired. To the fostering of this spirit among its young citizens may be attributed that thirst for information which characterises young Japan to-day. As a significant illustration of this spirit one may mention the formation among the students at Tokio of an association for speaking English, whose first meeting, attended by two hundred and thirty members, took place on May 13th. Papers, principally on elementary physiological subjects, formed the first part of its programme, and an address by Dr. Seaman, an American Army surgeon, the second. In this address Dr. Seaman mentioned that the spectacle of a body of students, voluntarily devoting their time to the acquisition of a foreign language, different in every respect from their own, illustrated more forcibly than anything else the determination of the rising generation to keep themselves *au courant* with the developments of their science in other countries than their own, and that already some of the speakers, first and second year students, had attained remarkable facility. Dr. Seaman himself had come from America to learn on behalf of his department how it was that, when the United States in their war with Spain lost fourteen men from disease to each one from wounds, England in the Crimea six men from disease to one from wounds, France in Madagascar more than two hundred of disease to one from wounds, and England in South Africa an even larger proportion than the United States in the Civil War—how it was that Japan in her Titanic conflict with Russia managed to keep the medical wards in her base hospitals practically empty. That the latter was the fact he had witnessed with his own eyes, and he attributed it to the care in minute organisation which was expended on the army for ten years before it was sent into the field. Reflections are kindled by words such as these addressed by an American to a Japanese audience, reflections that are by no means favourable to the conduct of the army medical officers of this country. Changes there have been, many of them for the better, but we still fail to see any sign that the proportions of the problem of keeping the British Army free from disease are grasped by the War Office and military authorities. The matter is one of fundamental and vital importance to the very existence of the Empire, especially in view of the smallness of our Army in the absence of conscription. The efficiency of our Army alone can form a sufficient excuse for its size, and preservation of its health and the conservation of its energy are factors which lie, or should lie, largely in the hands of the Army Medical Department. Till that fact is realised, tinkering with battalions, army corps, and volunteers may go on indefinitely without the slightest rise in the efficiency of the Army as a whole. A pleasing token of the esteem in which the medical men in the public services of Japan are held, was given by the Emperor, when he recently raised Professor Takaki, lately Surgeon-General of the Japanese Navy, to the rank of Baron, an event which caused much public rejoicing. Takaki's name is known throughout the world as the man who banished beri-beri from the Japanese Navy. His theory that kak-he is due to deficiency in nitrogen in the sailor's ration is not generally accepted by tropical pathologists, but by a revision of the diet scale he caused the annual invaliding from the disease in the Navy to fall from one-third of the total force to less than a sixtieth—a fact which it is difficult to explain on other grounds than those he adduced. Such are the men that Japan delighteth to honour.

Notes on Current Topics.

Tropical Light and White Men.

The increase of America's foreign interests, consequent on her occupation of the Philippines, has given an impetus to the study of tropical hygiene and medicine in the States. An interesting contribution to this study has been made by Major Woodruff, Surgeon of the United States Army, on the effects of tropical light on white men. The darker pigmentation of the skin noted in tropical and sub-tropical races has usually been explained as due to the greater heat to which they are subjected. It is not obvious, however, in what way darkness of skin could be related either causally or by natural adaptation to excessive heat. Woodruff argues strongly in favour of the hypothesis that it is as a protection against light rather than against heat that pigmentation of the skin has been evolved. While a certain degree of light is, both in animals and plants, highly helpful to the processes of life, an excess is directly hurtful. In particular, it has been shown that the short rays are deleterious to metabolism. Woodruff believes, therefore, that it is necessary for white men to take certain precautions against the effects of light when they have to live in the tropics, and he makes some useful suggestions. The clothes worn during exposure to sunlight should be impervious to the short rays, and for this purpose black or yellow underclothing is best. At the same time, the outer garment should be such as will reflect the sun's rays as much as possible, white or yellow being suitable colours. The hat should be wide and thick, and lined with tin-foil, and an umbrella should be carried. During the brighter hours of the day, one should stay under cover as much as possible. Tents should be avoided altogether, wooden shelters being used when houses are unavailable. It is interesting to note that the medical officers of the American army are thoroughly alive to the problems waiting them in their duties in the tropics.

Early Specialisation.

The degree to which specialisation is carried in medicine is often the subject of caustic remark on the part of the older generation, but so far in this country it has been held that all practitioners of separate branches of medical work should—if one excludes dentists—pass through the same course of general medical study before beginning to concentrate their energies on any particular branch. It has been left to the Harvard Medical School to introduce some variation in this salutary rule. With the opening of the academic year on May 1st an arrangement came into force by which students in their fourth year of study could make an unlimited choice of the subjects to which they would devote their attention, certain groups of subjects being suggested as presenting advantageous combinations under certain circumstances. Roughly, it would seem the aim of the promoters of the scheme was to train two separate classes of workers—those who would become clinical practitioners, and those who would give themselves to scientific work in laboratories. We are glad to hear that the large bulk of the students determine to take up clinical training, the numbers of those who aimed at laboratory work being small.

It is always a misfortune when any choice between clinical and pathological work takes place, for that physician who is not a fair pathologist is no physician, and that pathologist who is not a physician is, at the best, an incomplete pathologist. To import the distinction between medicine and pathology into the students' curriculum is early to foster a distinction which can never be anything but regrettable, and it may be trusted that many of the Harvard students who chose medicine will, eventually, from force of circumstances or taste, find their way to the laboratories in future life. They will at least have a better appreciation of the significance of the problems they are called on to solve than if they have specialised in pathology before being thoroughly *au fait* with the manifestations of disease in the wards.

"Maternity" and Cancer.

Professor Chiene, of Edinburgh, in a recent address (*a*) quotes Mr. Balfour as saying that the natural sciences are, as time goes on, leaning more and more on idealism. This, perhaps, may suggest to some extent the psychical attitude of Professor Chiene himself in the address to which we refer. He has, in fact, put forward a theory of the causation of cancer, which, even if there be no new thing under the sun, has at least at the present day the appearance of novelty. Every cell has, like every animal, two varieties of reproductive activity, the maternal and the paternal elements. The excess of the paternal in the male is maintained through the exercise by the testicle of its hidden function, while the ovary similarly maintains the preponderance of the material in the female. In case the balance is not even, it can be restored by adding to the one or the other element. Now the growth of a malignant tumour is "early uncontrolled maternity; the cells divide when unformed and undeveloped; they reproduce their like when in their childhood. Why? Because of their excessive reproductive power, their excess of maternity." This being so, all that is needed to check malignant growth is to restore the balance by increasing the paternal element. Consequently, Professor Chiene is dosing his cancer patients with "didymin," an extract of rams' testicles. He also suggests the possibility of producing an "anti-maternal serum" by inoculating an animal with repeated doses of ovarian extract, this serum to be then administered to patients suffering from malignant disease.

Immigrant Legislation.

Now that the Aliens Bill is being run through Parliament with such energy as to ensure its eventually reaching the Statute Book this session, it is not too soon to prepare the mind for the consideration of those points on which medical advice will be sought. The best guide to knowledge of the subject is the experience of America, where alien legislation, as far as medical examination and exclusion are concerned, has been in force since 1891. Dr. Heiser, in the *Medical Record* of June 17th, states that the medical features of the immigrant legislation fall under two heads, namely, that for the exclusion of those suffering from affections for which exclusion is absolutely necessary, and, secondly, those suffering from conditions which may make them become a charge on the public. Each year it was found advisable to add to the schedule of diseases under both these heads, till in 1903 a fresh Bill was passed widening the act, far beyond the scope of its predecessor in 1891. Among the maladies which make exclusion absolute, trachoma is by far the most common, whilst favus ranks next in importance. Leprosy, active syphilis, and cases of tuberculosis with bacilli in the sputum are also included. While many people would be adverse to tubercle being made an absolute cause for exclusion in this country, it would be an unmixed gain if syphilis could be so far stretched as to prevent the dumping on these shores of prostitutes turned out of foreign brothels for venereal diseases. The American law goes far in its absolutely excludable list, for epileptics, idiots and the insane are all specifically mentioned. The class of those whose illnesses, though not infectious or undesirable in themselves, make their subjects liable to become a public charge, is a long one, and includes hernia, nervous affections, heart disease, malignant tumours, defective eyesight, senility, and many others. In case of temporary illness, persons arriving by steamer are treated in the public hospitals at the expense of the transportation companies; in other cases it is not difficult to bring the patient under one or other of the numerous heads which prohibit anding.

The Dread of Cats.

Most of our readers have heard from time to time of people who are unable to bear the presence of cats in the room, or who suffer serious physical annoyance in their presence. Apart from the condition of cat asthma—asthma excited by the emanations from cats—a subject which has received detailed description from Dr. Byrom Bramwell and others, but little attention has been paid by scientific observers to antipathy to cats. Dr. Weir Mitchell, however, has recently collected material for the study of the question, and has made known the results of his inquiries. (*a*) He has satisfied himself without difficulty that there are many authentic cases of people who suffer from various curious symptoms as soon as they are aware of the presence of a cat. These symptoms vary from mere uneasiness or a "creepy feeling" to a state of absolute terror, causing a fear-paralysis or even convulsions. Vomiting is not uncommon. In all cases the symptoms disappear with the removal of the cat. In a few cases, Dr. Mitchell discovered that similar symptoms occurred in the presence of such animals as tigers

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(*a*) *Edin. Med. Journ.* June, 1905.

(*a*) *American Med*, May 27th, 1902.

and lions, though in most cases these animals were tolerated without annoyance. Apart, however, from cases where the sight of a cat was responsible for the sequence of peculiar symptoms, Dr. Mitchell found that there are many subjects who can tell the presence of a hidden cat. Some of these people recognise that they do so by an abnormally acute sense of smell, but most are unconscious of any such special sense impression. Dr. Mitchell thinks, however, that there is in all such cases an impression by the sense of smell, which, though itself remaining sub-conscious, may give rise to a train of symptoms which affect consciousness, and he brings serious analogical cases in support of the suggestion. It would appear that only people who suffer from the fear of cats—"allurophobia," as Dr. Mitchell terms it—have the power of detecting their presence while unseen. Of the cat fear itself he is unable to suggest any explanation.

Jewish Vital Statistics.

At the Royal Statistical Society recently, Mrs. S. Rosenbaum read an interesting paper on Jewish vital statistics. In London the Jewish birth-rate is estimated to be at the rate of 45 per 1,000 living as compared with 33½ in the case of London in 1903. The comparison being carried still further to allow for the difference in the proportion of married females at ages 15—45 among Jews and non-Jews, points rather to an appreciably greater fertility of Jewish women. The proportion of deaths under 1 per 1,000 births—generally known as the "infant mortality"—works out to 128 per 1,000. This is compared with the rate of 165 in the borough of Stepney, and 186 in the borough of Southwark during the years 1896 to 1900. The marriage-rate is estimated to be 19·2 persons married per 1,000 of the Jewish population, as compared with 17·4 only in the case of London. Allowance being made for the difference in the proportions of males and females aged 15 and upwards, it is shown that of those aged 15 and over, 1 in 35 males and 1 in 31 females are married annually among Jews; in London generally the proportions were 1 in 37 males and 1 in 44 females. The Jewish population of the United Kingdom is calculated to be just under 240,000 in the year 1903. Of this, 140,000 are in the London area, about 67,000 are in the rest of England and Wales, and about 25,000 in Scotland and Ireland. This population is increasing (1) by excess of births over deaths at the rate of about 5,000 per annum; (2) by immigration at the rate of 6,000 per annum. The following were the principal conclusions reached: 1. The death-rate from all causes and at all ages, except 0—5, is lower among the Jews than non-Jews in London. 2. The birth-rate is considerably higher. 3. The infant death-rate in proportion to number of births is very low. 4. The expectation of life at all ages for both sexes is higher. 5. The marriage-rate is higher. 6. The rate of natural increase is higher. 7. The present Jewish population of the United Kingdom is about 250,000.

Physical Degeneration.

We have always been warmly on the side of those enlightened and philosophic workers who, finding the physique of the nation not what it should be, are striving to bring about improvement by all reasonable agencies. At the same time, the "physical degeneration" cry has been carried too far in many quarters, as was shown by the report of the Departmental Committee on the subject, and we think it a pity that a good cause should suffer from bad advocacy. Things are sufficiently serious, but there is no need for exaggeration. If we turn our eyes to what is the case in other civilised countries, we shall find that the beef and beer of Britain still manage to raise a stock which compares not unfavourably with that of its neighbours. In New York forty-five inspectors were recently appointed to carry out investigations into the physical conditions of school children in the city, and 7,166 youngsters were examined by them. Of these 3,000, or nearly one-half, were pronounced to stand in need of medical treatment! A third of the children suffered from defective eyesight, and an almost equal number from bad teeth. The "underfed" numbered 632, and 650 were classified as having "bad mentality." A further examination showed that of the latter unsoundness of mind was due in most cases either to actual disease or to unhealthy surroundings. At any rate, the children were not fit for instruction in regular classes. All the school children are to be eventually examined with a view to determining whether they are likely to become victims of acute maladies—rather a difficult and delicate task, we should think—and whether their general health is good enough for them to be regularly enrolled in ordinary classes. Inspections such as these are probably more useful as testimonials to the advance of medical science in "spotting" deficiencies than as evidence of actual physical degeneration.

The Annual Election to the Council of the Royal College of Surgeons, England.

The annual election to the Council of the Royal College of Surgeons, which took place on Thursday last, the 6th inst., was in certain respects unique. First, of the six candidates nominated for the four vacancies, one withdrew—Mr. Bruce-Clarke—two days after the list had been issued. We do not remember an incident of the kind occurring before; indeed, we believe that it establishes a record in the history of these elections. It was a magnanimous act on the part of Mr. Clarke to have withdrawn his candidature, inasmuch as had he gone to the poll probably a good many votes of the St. Bartholomew's School, which he represented, would have been diverted from his senior colleague, Mr. Cripps. As it was, practically the full strength of the supporters of St. Bartholomew's was available for Mr. Cripps, with the result that he was one of the successful candidates. The other successful candidates were Mr. Edmund Owen and Mr. Godlee, who were re-elected, and Mr. Golding Bird. The only unsuccessful candidate was Mr. Andrew Clark, of the Middlesex Hospital. Here is another feature of the election: For the four vacancies there were virtually only five candidates—an absolutely unprecedented arrangement of the poll. While, however, this robbed the contest of most of its interest, at the same time it proved an exceedingly favourable occasion for the attainment of the ambition of those who competed. As we have before observed, the opportunity was a great one for the election of a Provincial Fellow; there can be no question that the Provincial Fellows have missed a splendid chance of adding to their already meagre representation on the Council. Under the circumstances a strong provincial candidate would have been almost certainly successful. College politics having reached a dead level, so far as the Fellows are concerned, the only element influencing the disposal of the suffrages was the personal one in this election. A great deal of canvassing was resorted to in the interests of the various candidates—not without effect, as the recorded result of the poll indicates; meanwhile there is only one detail more which can excite interest in the affairs of the College during the next twelve months, and that is the election of the President, which takes place at the first meeting of the Council succeeding the annual election.

A Crusade Against Cushions.

THERE is scarcely any custom of civilised life which does not come in for blame as a causative factor of disease. Thus we learn from a recent paper by Dr. Jerome D. Potts, of St. Louis (*a*) of the existence of a class of disorders called by him "Cushion Diseases," and due in his opinion to our preference of soft cushions to hard seats. Nature has provided us, Dr. Potts points out, with two bony prominences upholstered with tough, elastic cushions, with the design that we should sit upon them and not upon other parts. The consequence of scorning this wise provision of nature is that the neighbouring parts are, by our habit of sitting on cushions, subjected to pressure for which they are not adapted, with the result that these parts, being for long periods depleted of blood, suffer from deranged nutrition. At the same time, the increased local heat due to resting on a padded surface stimulates the secretion of the sebaceous and sweat glands, while escape of the secretion is prevented by pressure. In this combined interference with functions, Dr. Potts believes that an enormous variety of diseases has origin. Diseases of the skin and subcutaneous tissues, such as eczema, pruritus, and abscess; diseases of the mucous surfaces, such as urethritis, prostatitis, and anal ulcers; and diseases of the vessels and glands, such as piles, papillomata, and adenomata, are mentioned as the result of sitting on soft cushions. There is no doubt that Dr. Potts is right in pointing out that a hard seat has hygienic advantages over a soft one, but we fear he will have a hard task to persuade the world to carry his theories into practice.

Aerial Convection of Small-pox.

FOR many years, the question of the danger of a small-pox hospital to the population in its immediate neighbourhood has been under discussion. The general view at present is that the infection of small-pox may be carried by the air, and that consequently, apart from all defects of administration, a small-pox hospital constitutes a focus of disease for the neighbourhood. This view has been strongly supported by the case of the small-pox ships in the Thames, where disease spread to villages which had no communication whatever with the ships, and it only spread in the direction of the prevailing winds. The Local Government Board of England has, moreover, given this view official sanction by their regulation that a small-pox hospital must not have a population of six hundred within a radius of half a mile. All competent authorities have not, however, as yet given their adherence, and Dr. Claude Ker, from his experience at the Edinburgh City Hospital, is unable to find anything in support of the official view. (*a*) Within a quarter-mile radius of the Edinburgh Temporary Hospital at Colinton Mains there is a population of at least fifteen hundred, but in this district there was no excessive incidence of disease. Moreover, in the few cases that occurred it was possible to trace infection by ordinary means. Even among the inmates of the fever hospital within a hundred yards of the small-pox wards no case occurred. Dr. Ker is inclined to think that more careful administrative measures are responsible for the success of the isolation at Colinton Mains, and he has at any rate put forward a strong case against the aerial convection theory.

Whiskers.

DEMOCRACY and liberty are not always interchangeable terms, and the voice of the people may sometimes be as imperative and as autocratic as that of the deity with which it likes to be associated. At least, so we should judge from reading the regulations made from time to time by the health authorities in America. Far be it from us to decry any properly-directed energy in the regulation and preservation of the public health, but if we may believe a statement made in *Medical Notes and Queries*, the State Medical Board of Iowa, U.S.A., have gone the length of prohibiting the doctors in this State from wearing whiskers. The writer of the note, Dr. Willard Watson, attributes the order to the habit of the Western doctor of wearing his whiskers long, whereby countless hordes of bacteria are carried about on the

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(*a*) ***Med. Record***, June 10th, 1905.

(*a*) ***Edin. Med. Journal.***, June, 1905.

doctor's person. The "expert" who was employed by the State Board to make the investigations found microbes so large that it did not need a microscope to see them, and the Board was led to believe that the objects discovered by the "expert" must be the bacilli and bacteria of which they had long read but never hitherto seen. However, the fiat has gone forth, and the razor is to sweep the chin of the Iowa doctor who prefers continuous practice to losing his hirsute adornments. Dr. Watson humorously demands information from the State Board as to the destination of the whiskers, and bids the Board take care they are not used for stuffing cushions and mattresses until they have been disinfected from the "microbes." It would be interesting to learn what idea the term "disinfect" would convey to the State Board; perhaps they would regard it as "something lingering, with boiling oil in it."

The West London Hospital.

The acceptance of the Chairmanship of the West London Hospital by His Grace the Duke of Abercorn, K.G., has been cordially welcomed by the friends and supporters of that Institution. There is every reason for believing that under this new *régime* the prosperity of the Hospital will be still further increased. Funds have been recently raised for re-organising and rebuilding the casualty department—a much-needed improvement, and the work is on the point of being commenced.

Cancer Research.

All medical men will feel peculiar pleasure in the fact that the Prince of Wales continues to manifest the philanthropy that has always distinguished the members of the Royal Family, not only by his interest in the King Edward VII. Hospital Fund, but in the less showy but deeply practical matter of scientific research in pathology. This sympathy was evidenced by the holding of the third annual meeting of the Imperial Cancer Research Fund at Marlborough House, the Prince of Wales himself taking the chair. Nor is the interest of his Royal Highness merely a platonic one, for the Prince showed in the speech which he made at the end of the proceedings that he was well aware of the methods of the workers and of the value of their discoveries. Sir William Church gave an account of the year's work, and if many of the results that he had to announce were merely negative, at any rate the workers will be to a great extent disembarrassed of many difficulties in the way of their research by having a comparatively free path in front of them. Cancer, they found, was not associated with any particular diet, climate or mode of life, and, as the Prince of Wales informed the meeting, none of the many reputed remedies sent from all parts of the world for investigation have proved of any real service. Any value they may have seemed to possess, said his Royal Highness, was based on a misapprehension of the meaning of the term "cancer." The well-known experiments with mice were referred to, and it was pointed out how malignant growths could be propagated through several generations of mice, the cancer cells seeming to be endowed with the property of perpetual multiplication. No evidence of the infectivity of cancer was obtainable. The work of the Imperial Cancer Research Fund has so far been of high value, and we hope they will be encouraged by the past never to rest till they have solved the mysteries of the origin and cure of the disease.

Lady Somerset on a Drink Cure.

The medical world may well stand agape at the spectacle of a clergyman of the Church of England laying down the law as to the medicinal action of a proprietary drug in so complicated a disease as alcoholism. Yet the Rev. Hugh B. Chapman, vicar of St. Luke's, Camberwell, does not hesitate to take upon himself the terrible responsibility of advocating a secret remedy sold under the name of "Normyl," as a certain and absolute cure for the drink habit. From his position in the Church the worthy clergyman in question is presumably an educated man, at any rate, so far as the externals of modern college education go. It is hard to imagine, however, that a man, if his mind were really trained in exact methods, would venture to settle professional problems which have hitherto escaped the vigilant advances of modern scientific medicine. Yet, lo! here is a simple-minded suburban vicar firmly persuaded that he has unloosed the Gordian knot which has baffled so completely medical men all the world over. We are glad to learn that Lady Somerset, a distinguished practical worker in the cause of temperance, has spoken out her strong disbelief in Mr. Chapman's pet discovery. In the *Westminster Gazette* of July 4th, she says that after many years of study of the drink problem she has seen drunkenness arise from so many causes that the assertion that a cure can be obtained from a drug sent out in bottles and administered to all alike seems to her absurd. Bravo for the logic of a courageous and distinguished woman! say we. By the way, the reverend gentleman must have saved the proprietors of the quack remedy an enormous sum in advertisement. Has he thought out the commercial aspects of his advocacy, we wonder?

PERSONAL.

The Lord Mayor will give a dinner at the Mansion House, London, on Monday, the 31st instant, to celebrate the Tenth Session of the International Statistical Institute.

Professor Kanehiro Takaki, Retired Surgeon-General of the Imperial Japanese Navy, Director of the Tokyo Charity Hospital Medical College, and Member of the House of Peers, has lately been raised to the rank of Baron by the Emperor of Japan.

Dr. Matignon, a French doctor in the Japanese Red Cross Service, has invented a whistle, for the use of wounded soldiers on the battlefield, which, with but slight exertion, gives a loud sound, and which may be used in place of the soldier's ordinary identification plate.

AT the final congregations of the Cambridge term, held on June 20th, the honorary degree of LL.D., was conferred on the Right Hon. the Earl Cromer.

DR. JAMES RITCHIE, M.A., B.Sc., Fellow of New College, Oxford, Reader in Pathology, has been constituted Professor of Pathology so long as he holds the aforesaid Readership.

THE Gold Medal of Merit of the British Medical Association will this year be presented to Sir Constantine Holman, M.D., and to Mr. Andrew Clark, F.R.C.S.; and the Stewart Prize to Mr. W. Hy. Power, F.R.C.S., F.R.S., at the annual meeting of the Association, at Leicester, on the 25th instant.

DR. G. E. HERMAN, consulting obstetric physician to the London Hospital, has been elected an honorary member of the Gynæcological Society of Chicago.

LIEUTENANT-COLONEL L. E. ANDERSON, is appointed to the medical charge of the Cambridge Hospital, Aldershot, and to command No. 1 Company, vice Lieutenant-Colonel H. W. Hubbard.

FLEET-SURGEON FRANCIS AUSTEN JEANS has been promoted to the rank of Deputy Inspector-General of Hospitals and Fleets in His Majesty's Fleet.

AT a meeting of the Council of the University of Birmingham held on Wednesday last, Professor Saundby, M.Sc., M.D., LL.D., F.R.C.P., was appointed Representative of the University on the General Medical Council of Education of the United Kingdom.

PROF. HERMAN NOTHNAGEL, the renowned scientist and physician, of Vienna University, died suddenly of apoplexy last week, aged sixty-five. His important discoveries concerning diseases of the brain and heart were made before he attained world-wide fame as a clinical teacher and humanitarian.

MISS EVA C. E. LUCKES, matron of the London Hospital, has been presented by the medical and surgical staff with a silver tea and coffee service, "in recognition of the completion of the twenty-fifth year of her matronship, and as a memento of the staff's appreciation of the great work performed by her in raising the standard of nursing to its present high state of efficiency."

CONSIDERABLE stir has been caused in medical circles in Germany by the resignation of Professor Schweninger from active work. This well-known medical man first became famous as Prince Bismarck's body physician and confidential friend. He filled in recent years the position of director of the large hospital at Gross Lichterfelde, near Berlin.

ON the 3rd inst., Sir Alfred L. Jones entertained a number of gentlemen at dinner at the Palatine Club, Liverpool, to inaugurate a new movement under the title of the Liverpool Tropical Research Institute.

H.R.H. THE DUKE OF CONNAUGHT last Saturday inspected the London companies of the Royal Army Medical Corps at Knightsbridge Barracks.

YESTERDAY, Tuesday, July 11th, before the Society for the Study of Inebriety, at its meeting in the Rooms of the Medical Society of London, Dr. Thomas Claye Shaw, opened a discussion on "The Psychology of the Inebriate." An abstract of Dr. Claye Shaw's paper appears in our present number.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

SCOTLAND.

EDINBURGH ROYAL INFIRMARY RESIDENTS' CLUB.—The eleventh annual dinner of this club took place on June 30th, the occasion being rendered sepecially interesting by the presentation to Dr. Claude B. Ker, the late secretary, of a handsome silver salver, on the occasion of his marriage. Dr. Claude Ker was one of, if not *the* originator of the Club, which has, during its eleven years of existence, proved an immense success in keeping the seniors and juniors of the profession in touch with one another. Professor Annandale, the President, in a humorous speech narrated several anecdotes of his old residency days, and in handing over to Dr. Ker the salver, wished him "as many joys of prospect and retrospect in the new residency he was about to enter as in that residency whose happy memories he had done so much to perpetuate." Among other officials of the club is one known as the "custos vestigiorum," and into his keeping was handed by Mr. Cotterill a ladle which had been used by the late Mr. Porter for thirty years for doling out soup to the patients.

TRACHOMA AMONG ALIENS IN GLASGOW has excited the watchful interest of the sanitary authorities, and Dr. Chalmers has just issued a report on the prevalence of the disease. As is known, candidates for emigration to America are required to submit to examination for trachoma, and a not inconsiderable number are rejected on account of the disease. The cases are divided into four groups:—(1) Those who arrive at Glasgow simply as a stage on their journey; of these ten a month are rejected. (2) Those who book to Glasgow, and immediately again book from Glasgow to America; of these five a month are rejected. (3) City emigrants, who after working in Glasgow wish to emigrate; of these only one a month is rejected. (4) County emigrants, who have laboured in Lanarkshire for variable periods, and then desire to go to America; these supply the largest number of rejections—23 a month. These figures point to the disease being most prevalent among aliens who have resided in Scotland for some time, and are against the view that trachoma is present chiefly in transmigrants. Of rejected candidates, about a quarter remain in Great Britain, and three quarters return to their homes. The United States authorities have found it needful to take steps to prevent the importation of the disease, and it seems highly desirable that some enactment should exist in this country to prevent the introduction of a malady which is as alien to the population as the sufferers themselves are.

Correspondence.

THE USE OF PESSARIES UNDER DIFFICULTIES.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I must express my thanks to Dr. Duke for the notice he takes of my communication on the above-named subject, and the generally favourable opinion he expresses of it. He has, as is well known, a mechanical bias, and I can well understand how it is that he uses pessaries with success. In teaching a patient to take out, clean, and re-insert a pessary I do not go quite so far as Dr. Duke assumes. I do not ask the patient, or expect her, to "replace the uterus." I only teach her to replace the pessary. If the pessary has done its work the uterus will not become displaced again the moment the instrument is withdrawn, but only after rising in the morning. As a matter of fact, the cases in which I have trusted the removal of pessaries to the patient themselves have generally been those of prolapse with slight backward displacement.

As regards the horizontal position, I simply mean that, quite regardless of whether it is the lateral horizontal or the prone or supine horizontal. I only desire to get the column of blood level and the downward pressure of the abdominal viscera taken off the internal genitals. Perhaps in theory the prone position would be the best for cases of retroversion, as there the position would help the uterus forwards.

As regards his denial of my "sweeping statement, 'that no man will be successful in these cases without first putting his patient to bed,'" my paper distinctly excluded the cases that could be so easily treated in the consulting room and at the first visit, and did not apply to them at all. That Dr. Duke would succeed, however, when the majority of practitioners would fail, I have not the least doubt, and I should say the same of any man who was possessed of knack and was not discouraged at a first failure, for here as elsewhere, "where there's a will there's a way." There is truth, no doubt, in what Emmett says about necessity for "decided mechanical talent" in the proper fitting of pessaries, but I am suspicious that it is not so much the talent that is wanting as the will to put it to a good use, which—and I think Dr. Duke will agree with me in this—is a great pity.

I am, Sir, yours truly,
J. E. Burton,

Liverpool, July 10th, 1905.

THE DISCOVERER OF THE CIRCULATION OF THE BLOOD.

To the Editor of the Medical Press and Circular.

Sir,—Those who are interested in such a question as you deal with in your article "Discoverer of the Circulation of the Blood" may get some idea of what the views of the profession were in this country by carefully looking through the works of Thomas Sydenham, M.D. Sydenham and Harvey were contemporaries; the one a great physician, the other a great anatomist. There is not the least doubt but that the greatest ignorance prevailed of how the circulation of the blood was carried on. It was how to disperse those clouds of ignorance and error that Harvey had chiefly to think of and work out. The establishment of a New Law or Principle is very different from the discovery of a new fact. Harvey spent far more time and thought on the anatomy of the ovum than on that of the heart. Those who care to look into the value of Harvey's work would do well to read carefully Froude's Essay on "England's Forgotten Worthies."

"It is almost impossible to throw back our imagination into the time when, as new grand discoveries, they stirred every mind which they touched with awe and wonder at the revelation which God had "sent down among mankind," and "strangely failing to see that the real value of the actions or the thoughts of remarkable men does not lie in the material result which can be gathered from them, but in the heart and soul of the actors or speakers themselves."

I am, Sir, yours truly,
R. L.

July 7th, 1905.

Obituary.

Dr. ROBERTS DUDLEY, J.P.

We regret to announce that last week Dr. F. J. Roberts Dudley, J.P., the medical officer of health to the Stalybridge Corporation, was found dead in bed. The cause of death was angina pectoris. The doctor had been ill for twelve months or more, but he was out on Saturday as usual attending to his professional duties. He was the oldest magistrate on the borough bench, his name having been placed on the commission in 1874. He was medical officer of the borough for thirty-two years, vaccination officer for the district, and medical inspector under the Factories Acts. A Rochdale man by birth, he came into the Stalybridge district some forty-five years ago. He was 64 years of age.

Literary Notes and Gossip.

Le Radium is the name of a new monthly journal devoted to radio-activity and radiations, and the sciences related thereto. The Editorial Committee comprises MM. d'Arsonval, Becquerel, Béclere, R. Blondlot, Ch. Bouchard, P. Curie, Danysz, Debierne, Ch. Féry, Ch. E. Guillaume, Oudin, Rubens, and Rutherford.

⁂

It is frequently said that the British, more especially the professional classes, are very small book-buyers. In this connection it may be of interest to hear that one of the numerous medical publishing houses in London, Messrs. Bailliere, Tindall and Cox, have put on the market the enormous total of 105,325 copies of books and pamphlets during 1904 in spite of the generally recognised fact that that year was the worst on record in the publishing trade.

⁂

Edinburgh lies *en route* to so many summer homes and autumnal rambles that many of our readers will be pleased to know of some recent and discursive information about this most interesting of our northern cities. Such would enjoy the pleasant-reading "Auld Reekie" article in *Blackwood's Magazine* for July. It is just adapted for reading in a train, or an evening at an hotel. Full of information, literary and archæological, yet in no way pedantic or prosaic. In all respects it is worthy of Mega's best days.

⁂

Sir T. McCall Anderson's "Plea for the More General Use of Tuberculin" cannot fail to attract attention at a time when the therapeutical applications of these preparations are being laboriously worked out. This particular "plea" having been delivered before the Dermatological Society, the author has confined his remarks to forms of tuberculosis associated with cutaneous manifestations, but the results that he has obtained stimulate one's desire to study the employment of the tuberculins in the more recondite forms—visceral and osseous tuberculosis, for example. It is extremely interesting to find that tuberculin injections have proved markedly beneficial in a case of Addison's disease, especially as the clinical evidence points to a direct local effect on the suprarenal capsules preceding the improvement. We are familiar with the remarkable curative action of tuberculin in lupus and *cæteris paribus* the method of treatment is much simpler and cheaper than the popular light treatment. The *brochure* is liberally supplied with excellent illustrations of the effects of treatment in lupus of the face.

⁂

The current number of *The British Journal of Inebriety* (the official organ of the Society for the Study of Inebriety), edited by Dr. T. N. Kelynack, contains an important article on the Medico-Legal Aspects of Alcoholism, by Dr. Stanley B. Atkinson, and a controversial essay on the hereditary influence of alcoholism, by Dr. Archdall Reid, together with other papers opportune and valuable.

⁂

Sir Victor Horsley's Lecture on "The Effect of Alcohol upon the Human Brain" has recently been issued by the Lees and Raper Memorial Trustees, in convenient pamphlet form.

Medical News.

An epidemic of typhoid fever has broken out in some quarters of Madrid.

Legacies for Dublin Hospitals.

Mr. Patrick Birmingham, of Kingstown, recently deceased, left by his will over ten thousand pounds for various charitable, religious, and educational objects. Among the bequests are £250 to the Hospice for the Dying, £250 to Jervis Street Hospital, £250 to the Holles Street Lying-in-Hospital, and £250 to St. Michael's Hospital, Kingstown.

Medical Sickness and Accident Society.

At the usual monthly meeting of the Medical Sickness,*Annuity and Life Assurance Society held on the 30th ult., there were present the Chairman, Dr. de Havilland Hall, Dr. J. Brindley James, Dr. J. H. Dempster, Dr. Sinclair B. Shadwell, Dr. F. J. Allan, Dr. F. S. Palmer, Mr. F. S. Edwards, Dr. W. Knowsley Sibley, and Dr. J. B. Ball. The accounts presented showed the society to be progressing satisfactorily. The claims have lessened since the early spring and are now under the average expected from the Sickness Experience Tables, upon which the rates of contribution to the Society are based. The number of new entrants is also showing satisfactory growth. During the first half of the current year the number of new members is appreciably greater than in the corresponding period of 1904, and as the Society pays nothing for commission or advertisement this shows that the members are responding to the appeal of the Committee to bring the advantages offered by the Society under the notice of their professional friends. Prospectuses and all particulars of Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Royal College of Surgeons.

A meeting of Fellows was held at the Royal College of Surgeons of England, on Thursday, for the election of four members of the Council. The result of the poll was as follows:—Mr. Edmund Owen (re-elected), of St. Mary's Hospital, 512 votes; Mr. Rickman J. Godlee (re-elected), of University College Hospital, 471 votes; Mr. C. H. Golding-Bird, of Guy's Hospital, 480 votes; and Mr. W. Harrison Cripps, of St. Bartholomew's Hospital, 373 votes. In the evening about 100 Fellows dined together at the College. Mr. John Tweedy, president, took the chair, and was supported by, among others, Mr. Thomas Bryant, Sir Thomas Smith, Mr. Reginald Harrison, Mr. John Langton, Mr. Mayo Robson, Mr. Henry T. Rutlin, Colonel Pilcher, Mr. John Poland, and Mr. Henry Colgate.

Royal College of Surgeons in Ireland.

The following prizes were awarded last week to students in the School of Surgery for the Summer Session, 1905:—

Barker Anatomical Prize—£26 5s., T. A. Burke; Special Prize, £21, J. B. Kelly.

Carmichael Scholarship—£15, R. M. Bronte.

Gold and Silver Medals in Operative Surgery—Gold—J. Prendiville; Silver—R. Bury and L. Lucas (equal).

Stoney Memorial Gold Medal in Anatomy—T. Sheehy.

Practical Histology—G. C. Sneyd, First Prize, £2, and Medal; E. Harrison, Second Prize, £1, and Certificate.

Practical Chemistry—Miss A. F. Nash, First Prize, £2, and Medal; T. A. Peel, Second Prize, £1, and Certificate.

Public Health and Forensic Medicine—C. J. B. Dunlop, First Prize, £2, and Medal; W. E. M. Hitchins, Second Prize, £1, and Certificate.

Materia Medica—C. J. B. Dunlop, First Prize, £2, and Medal; V. J. Clifford, Second Prize, £1, and Certificate.

Biology—E. A. Gregg, First Prize, £2, and Medal; E. Harrison, Second Prize, £1, and Certificate.

The next Preliminary Examination is fixed for Tuesday, September 26th. The School of Surgery will resume work on Monday, October 2nd.

Society of Apothecaries of London.

The following candidates passed in:—Biology (Primary Exam, Part 1)—U. J. Bourke, R. S. Minchin. *Chemistry*—H. S. Brown, R. J. W. McKane. *Materia Medica and Pharmacy*—W. E. Dimond, L. R. Nezet, P. D. Pickles, C. J. Wolfe. *Anatomy* (Primary Exam., Part 2.—L. G. H. Furber, W. J. Gibson, T. Huddleston, C. J. M. Lawrence, E. A. Mordaunt, G. F. Page, A. Perlman, P. A. Sullivan. *Physiology*—L. G. H. Furber, T. Huddleston, C. J. M. Lawrence, P. J. Lush, E. A. Mordaunt, G. F. Page, P. A. Sullivan.

University of Birmingham.

The following is a list of successful candidates in the Faculty of Medicine, June, 1905:—

Degrees of Bachelor of Medicine and Bachelor of Surgery.—Frank Marsh; Class II.—Edward Lancelot Bunting, Leonard Leigh Hadley, William Claude Horton, William Cuthbert Houghton, Henry Percy Pickerill, Thomas Holmes Ravenhill, Norman John Lancelot Rollason, *Frederick Wilkinson.

Fourth Examination for the Degrees of M.B., Ch.B.—Class II.—*Herbert Charles Horace Bracey, Lionel Chattock Hayes, Arthur Cecil Hincks, Claude Johnson, Walter Rowland Southall Roberts.

Third Examination for the Degrees of M.B., Ch.B.—Class II.—Edward James Boome, Henry Neville Crows, *James Fenton, Eric Thomas Gaunt, John Kennedy Gaunt, Philip James Mason, Nevill Coghill Penrose, Arthur John Smith, Rupert Wesley Thompson, Francis Brett Young.

Second Examination for the Degrees of M.B., Ch.B.—Class II.—John Adams, Charlotte Bailey, *Mary Clarke, George Henry Chavasse Mold, John Lichtenstein Ritchie, Herbert Henry Sampson, Edward Vernon Whitby.

First Examination for the Degrees of M.B., Ch.B.—Class I.—Cranston Walker. Class II.—James Henry Bampton, Walter Charles Blackham, Norman Alexander Boswell, Charles William Hayward, Humphrey Francis Humphreys, Violet Maud McCready, Arthur Harry Newton, Kenneth Douglas Wilkinson, Harry Wilks.

Degree of Bachelor of Dental Surgery.—Reginald Hudson Astbury.

Degree of Bachelor of Science in Public Health.—Robert Arthur Lyster, Sydney Herbert Hawley, William Sisam. *Scholarship.

Trinity College, Dublin.

List of candidates who passed the final examination, Section B., at Trinity Term, 1905:—Francis R. Coppinger, John D. Sands, Thomas H. Peyton, Richard A. Connell, John C. P. Beatty and Edward Gibbon (equal), W. Gustav Thompson, Basil G. Brooke and Robert B. Jackson (equal), Samuel G. S. Haughton, Thomas J. Cobbe, William I. Thompson, Henry D. Drennan, Alfred C. Elliott, Percy B. Egan, Ernest C. Phelan, Herbert J. Wright, Theodore C. Somerville, Dudley F. Torrens, Malcolm K. Acheson, Daniel M. Corbett, Thomas L. deCourcey, Herbert R. R. Fowler.

The Royal University of Ireland.

The following candidates have passed the First Examination in Medicine:—Joseph Anderson, William J. Ashby, James S. Bellas, Francis Bradley, Percy M. J. Brett, James A. Brown, Bartley Byrne, Samuel Campbell, Samuel R. Campbell, Francis S. Carson, Albert, V. Craig, Albert T. Crowley, Patrick J. Cullinan, William Dickey, Ernest S. Dixon, William Doolin, Francis Harold Duke, Francis P. Ferran, B.A.; David J. Foley, William A. Frost, John J. Gilmore, James A. Hanrahan, John H. Harbison, Arthur V. J. Harrison, Patrick Hayes, Richard W. G. Hingston, Jeremiah Holland, David Horgan, John C. Houston, David J. Jackson, Edward G. Kennedy, Ernest W. Kirwan, Bertram C. Letts, Denis Lynch, James McCormick, Barkley McCullough, B.A.; George E. A. Mitchell, Eileen M. O'Keeffe, James M. O'Reilly, Charles Ronayne, Peter J. Ryan, Thomas Scanlan, John Spence, Alfred M. Thomson, Michael Twohio, John F. Walsh, William O. Wilson, Robert Young. The following candidates have qualified upon their answering to present themselves for further examination for Honours in the subjects set after their names. Those qualified in two or more subjects may present themselves for the further examination in all subjects:—Joseph Anderson, Botany; William J. Ashby, Physics; James S. Bellas, Botany; James A. Brown, Physics; Samuel Campbell, Botany and Chemistry; Samuel R. Campbell, Chemistry and Physics; Francis S. Carson, Botany; Albert V. Craig, Chemistry; William Dickey, Botany and Zoology; Francis P. Ferran, B.A., Botany, Zoology, Chemistry, and Physics.

Notices to Correspondents, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Coroner.—Distension of the lungs in drowned persons is taken as a sign of life when they entered the water. Margulies believes the shock of the cold water causes a deep inspiration, which air cannot be expelled if complete submersion takes place.

Dr. F. (Nigeria).—The effect of anti-propagation measures against mosquitoes must always be a reduction of the mosquito density, not only within the area of operation, but to a distance equal to the ideal limit of migration beyond it.

L. S. A.—The Scotch and Irish Schools commence the Winter Sessions rather later than the English ones. Full particulars are given in our September Students Number.

Dr. H.—Embalming in London is practised more than you suppose. The Anglo-American Embalming Company in Tottenham Court Road, London, W., publish a small paper on the subject.

Dr. Alice F. (Dublin)—The first lady doctor in Hungary was Miss Charlotte Steinberger. You should advise your friend to seek one of the many medical posts under the L.C.C. They are well paid.

Surgeon (Derby).—Dr. Alexander Duke claims to be the first to suggest the "hot-water operating table."

M. O. H. (Rutland),—In 1904, in Persia alone, 70,000 persons died of cholera. Europe is assailable by four ways; by Moscow, St. Petersburg, and the Baltic Ports, by Odessa, and the Black Sea route, and Constantinople.

THE MEDICAL ACT AMENDMENT BILL.

B. (Manchester).—The Medical Act (1886) Amendment Bill passed its second reading in the House of Commons on Friday last, so that there is the chance of its escaping the "slaughter of the innocents" this year.

One Interested.—The subject is under consideration, but it is one beset with so many difficulties, that time only can solve. Your suggestions, however, are useful, and we tender our thanks for them.

Fourth Year's Student.—The advice given you as to the two manuals of "Medicine" and "Surgery" cannot be improved upon.

M. A. D.—The gentleman to whom you refer has retired from practice.

T. A. S. P.—The matter will receive our attention in an early issue.

M. E. D.—No.

Yeddo.—The incident has not come under our notice.

H. S.—Your letter is unavoidably crowded out.

Meetings of the Societies, Lectures, &c.

Wednesday, July 12th.

Therapeutical Society (Royal Botanic Society's Gardens, Regent's Park).—Garden Meeting to view the Medicinal and Other Plants.

Dermatological Society of London (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. Meeting.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. J. Berry: Clinique. (Surgical.) 5.15 p.m. Dr. J. Fawcett: Cancer of the Stomach.

Thursday, July 13th.

British Gynæcological Society (20 Hanover Square, W.).—8 p.m. Dr. C. Maunsell: (1) A Case of Endothelioma Uteri, illustrated by drawings and microphotographs. (2) An Improved Method of Ventrofixation of the Uterus, illustrated. Dr. H. Macnaughton-Jones: (1) Note on Cyllin as a Post-operative Antiseptic. (2) Note on a Case of Post-operative Parotitis. (3) Note on a Case of Urethral Cyst.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. D. Sommerville: Errors of Digestion in Relation to Disease.

Mount Vernon Hospital for Consumption and Diseases of the Chest (7 Fitzroy Square, W.)—5 p.m. Lecture:—Mr. H. Barwell: The Diagnosis of Tuberculous Laryngitis in its Early Stage. (Post-Graduate Course).

Friday, July 14th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.)—4 p.m. Mr. H. W. Dodd: Clinique. (Eye.)

Vacancies.

Middlesex Hospital, London, W.—Lady Superintendent. Salary £150 per annum, with board and residence. Applications to F. Clare Melhado, Secretary Superintendent.

The Victoria University of Manchester.—Junior Demonstrator in Physiology. Salary £100 per annum. Applications to the Registrar.

The Hospital for Consumption and Diseases of the Chest, Brompton.—Resident Medical Officer. Salary £200 per annum, with board and residence. Applications to the Secretary.

Borough of Leicester—Education Committee.—Medical Officer. Salary £400 per annum. Applications to T. Groves, Secretary, Education Department, Town Hall, Leicester.

Dorset County Hospital, Dorchester.—House Surgeon. Salary £100 per annum. Applications to W. E. Groves Valetta, Icenway, Dorchester.

North Staffordshire Infirmary and Eye Hospital, Hartshill, Stoke-upon-Trent.—Senior House Surgeon. Salary £100 per annum, with furnished apastments, board, and washing. Applications to the Secretary and House Governor.

The Royal National Hospital for Consumption, Ventnor.—Senior Resident Medical Officer. Salary £200 per annum, with board and lodging in the Hospital. Applications to the Secretary, 34 Craven Street, Charing Cross, London.

Bradford Poor Law Union.—Resident Assistant Medical Officer Salary £100 per annum, with rations, apartments, and washing Applications to George M. Crowther, Clerk to the Guardians Union Offices, 23 Manor Row, Bradford.

Appointments.

Ledingham, J. C. G., M.A., B.Sc., M.B.Aberd., Assistant Bacteriologist to the Serum Department, Lister Institute, Elstree.

Morris, L. N. L.R.C.P.Lond., M.R.C.S., Assistant House Surgeon at the Bristol General Hospital.

Oliver, W., L.R.C.P., L.R.C.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Coxhoe District of the county of Durham.

Paton, E. Percy, M.D.Lond., Examiner in Anatomy to the Society of Apothecaries of London.

Richardson, A. G., M.B., C.M.Edin., Certifying Surgeon under the Factory and Workshop Act for the Rhayader District of the county of Radnor.

Richardson, A. W. Cecil, M.B.Lond., Casualty House Surgeon at the Bristol General Hospital.

Richmond, G. E., M.D., B.S., B.Sc.Lond., D.P.H.Cantab., the London County Council Resident Medical Officer to the Rotherhithe Tunnel Works.

Sheppard, A. L., M.B., Casualty Officer at the Bristol Royal Infirmary.

Short, Arthur Rendle, M.D., B.S., B.Sc.Lond., House Physician to the Bristol General Hospital.

Births.

Jones.—On July 2nd, at Claybury, Woodford Bridge, Essex, the wife of Robert Jones, M.D., of a daughter.

Martin.—On July 2nd, at Netley, Hants, the wife of Major C. B. Martin, R.A.M.C., of a son.

Marriages.

Bradley—Cadbury.—On July 6th, at the Friends Meeting House, Birmingham, Neville Bradley, M.B., son of Frederic Bradley, Thornton Hall, Cheshire, to Margaret, fourth daughter of the late Richard Cadbury, J.P., Uffculme, Birmingham.

Robinson—Sibbald.—On July 4th, at Dunga Gali, Murree Hills, India, Captain J. H. Robinson, R.A.M.C., eldest son of Edward Robinson, Esq., Paymaster-in-Chief, R.N. (retired), to Harriett Graham, fourth daughter of the late Sir John Sibbald, formerly one of H.M. Commissioners in Lunacy for Scotland.

Warren—Buchanan-Dunlop.—On July 6th, at Christ Church, Reading, Alfred Castle Warren, M.R.C.S., L.R.C.P., of 13 Campden Hill Square, London, son of the late William Warren, of Dibrugarh, Asiam, to Sabina, (Ina), eldest daughter of Lieut.-Colonel H. D. Buchanan-Dunlop, R.A. (retired), of Whitley Rise, Reading.

Deaths.

Anderson.—On July 5th, at 9 Kerrison Road, Ealing, after a very brief illness, Fleet-Surgeon Robert William Anderson, R.N. aged 49.

Cameron.—On July 5th, at Edinburgh, Robert W. D. Macmartin Cameron, M.D.Sc., late of Newton Stewart, N.B.

Metcalfe.—On July 3rd, at Clifton Gardens, London, Edmund Metcalfe, F.R.C.S., in his 86th year.

Smith.—On July 5th, at Orleans House, Regent's Park Road, London, Cyrus Walter Smith, L.R.C.P.Lond., M.R.C.S., the beloved and only surviving son of Walter Smith, M.D., M.R.C.P.Edin., and Susan Smith of above address, aged 32 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, JULY 19, 1905. No. 3.

Original Communications.

IN DEFENCE OF THE PESSARY.

By GEO. GRANVILLE BANTOCK, M.D.EDIN.,
Consulting Surgeon to the Samaritan Free Hospital. (a)

Two papers have recently appeared on the subject of the use of the Pessary, the one entitled "On the Application of Pessaries and their Dangers;" (b) and the other "Pessaries: their Uses and Limitations." (c) Both of these contain statements which challenge criticism.

With regard to the *dangers* of the pessary it would be quite as much to the point to speak of the dangers of the scalpel. The dangers arising from the use of the pessary are due to ignorance, want of skill, or carelessness on the part of the practitioner, or to ignorance and carelessness on the part of the patient. The practitioner is either ignorant of the principles of its proper use, or deficient in skill in employing it, or careless as to the instructions he gives the patient; or the latter, being wholly ignorant of the subject, is careless in carrying out her instructions.

The authors of these papers seem to have brought together the *possibilities* of danger as a peg on which to hang a plea for surgical interference, but they are unable to produce any evidence in support of their argument. They are much taken up with "the pathological conditions (in the words of one of them) which contraindicate the use of any pessary, and where its presence constitutes a distinct danger." The use of a pessary under these circumstances must surely be regarded as an indication of gross incompetence.

With regard to their "uses and limitations," I am in accord with much of the argument of the writer, but when he speaks of them as a *necessary evil* I entirely disagree with him. If this be correct, then, any operation or method of instrumental treatment is a necessary evil—even the wearing of a set of false teeth. Now there are only four conditions affecting the uterus to which the use of a pessary is applicable. These are uncomplicated retroversion, anteflexion, retroflexion, and prolapse. Perhaps I ought to include elongation of the cervix; but as it is usually associated with some prolapse of the whole organ it scarcely deserves to be erected into a separate class. The enumeration of the various pathological conditions that may be associated with these serves only to obscure the subject, for they, not the displacement, become the subject of our solicitude. But the examples of the *abuse* of the pessary enumerated by this author are quite to the point. When, however, he says that "properly fitting pessaries, rightly applied, have enough to answer for in the way of drawbacks and complications," I find another point for disagreement. It may seem trifling with the subject to ask the question, "What is a displacement?" But it is not so, as a proper answer to this question is absolutely necessary. A displacement, properly so-called, is a departure of the uterus from its normal *position*. Hence there is in reality only one form of displacement, viz., retroversion. I am glad to find that there is a general acknowledgment that anteversion of the uterus is not a pathological condition *per se*. This is the position I took up nearly a quarter of a century ago, but it has not yet met with acceptance by the author of the first paper. The normal position of the uterus with regard to the axis of the vagina is one of anteversion, and to speak of anteversion as a displacement is obviously incorrect. Among writers on this subject generally—and this is characteristic of the two above referred to—no distinction is drawn between *retroversion* and *retroflexion*. Schultze, in one of his tables, groups these under the head of retroflexions, and in another brackets them. Now a retroversion means a *turning* backwards, and a retroflexion a *bending* backwards, of the organ. This is a distinction with a mighty difference, and ought to be kept clearly in view. No work with which I am acquainted, with the exception of that of Hart and Barbour, clearly observes this distinction. Others use the terms as being synonymous. Hence we find the greatest discrepancy as to their relative frequency. This is seen in a table of Schultze's in which he gives, under the head of retroflexion the experience of various authors, the frequency ranging from 12 to 198 "per 1,000 cases of diseases of women," from 200 to 297 "per 1,000 displacements," and from 84 to 550 "per 1,000 flexions."

Strange to say, the distinction between *anteversion* and *anteflexion* seems to be observed. Of the first Klob says, "As a matter of course, anteversion *cannot* attain a very high degree." To this I may add that any exaggeration of this, which I call the normal condition will be due to a pathological state which then becomes *the* point for consideration. I do not know why so many gynæcologists of the day should persist in saying that anteflexion is the normal form of the virgin uterus. It is not so described in "Quain's Anatomy," but is represented as being quite straight. No notice appears to have been taken of the special investigation of Bandl, who as the result of *post-mortem* examination of a large number of cases arrived at the following conclusions:—"In the new-born the uterus was partly straight, partly in slight anteflexion, lying in the pelvic axis." "In older children, in whom the body of the uterus has acquired greater firmness, that organ is far more frequently found straight." "The straight form of the uterus is frequent as compared with the anteflexed."

A great deal has been written about the causes of uterine displacement. I particularly refer to retroversion. I do not see how any knowledge of this kind can help us in the least in the matter of treatment. We are not called upon to prevent displacement, but to remedy it, except in the case of a patient who has been the subject of displacement previous to a pregnancy which had been brought about perhaps, or at least aided, by the application of a pessary—of which I have seen many examples. The surgeon is not aided in his treatment of a broken leg by a knowledge of the way in which the fracture has been sustained. The only opportunity for practising preventive treatment arises when the subject of a retroversion has become pregnant while wearing a pessary, or was known to have a retroversion at an early stage of pregnancy. In such a case the patient should not be allowed to lie on the back during the puerperium, and the earliest opportunity should be taken to ascertain the position of the uterus. Such a case has come under my notice while writing this paper. Some few years ago I found the patient to be the subject of a very bad laceration of the perineum, a large rectocele, a smaller cystocele and a well-marked retroversion. I restored the perineum with a view to a subsequent pregnancy, and applied an Albert Smith-Hodge's pessary, which gave immediate relief to very distressing symptoms. In January last, after the lapse of about seven years, and believing herself pregnant, she again consulted me, earnestly desiring that I should produce abortion because she was afraid she might have a repetition of her former trouble. I comforted her on this point, instructed her not to lie on her back after delivery, and wrote to her medical attendant. My instructions were rigidly carried out, and when she came to me at the end of three weeks I found the uterus in perfect position. My intention was to apply a pessary if the uterus showed any sign of becoming retroverted, for if taken at this early period a cure can be confidently anticipated. That a retroversion is sometimes caused by a fall on the buttocks, or even on the face is unquestionable—of both of these I have seen several examples—but I do not see how this knowledge affects the treatment. We may tell women that they must avoid falling in either of these ways, lifting heavy weights, or straining at stool. But probably in 999 cases out of a 1,000 this advice would be useless. Hence disquisitions on etiology appear to me to be labour lost.

(a) Read before the Edinburgh Obstetrical Society.

(b) Macnaughton-Jones, MED. PRESS AND CIRC., Vol. CXXII, page 439, etc.

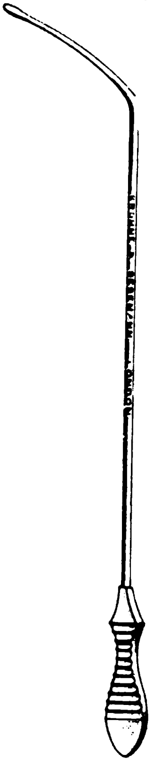
(c) Arthur Giles, MED. PRESS AND CIRC., Vol. CXXIX, 1904, page 1, etc.

A knowledge of the frequency of displacement, or malformation in the female population is obviously unattainable. But we can form an approximate idea of their comparative frequency. According to my experience the three states of retroversion, anteflexion, and retroflexion stand in the order of frequency as I have named them. Retroversion with anteflexion is so very rare that it may be regarded as a curiosity, and scarcely deserving of being erected into a separate class. I have seen but very few cases in an experience of forty years. Two of these are recorded in my little book on the "Use and Abuse of Pessaries," and as far as I know they were the first observed.

Now, given a case of uncomplicated retroversion, in which the uterus is perfectly mobile and capable of being raised into its normal position, either bimanually or by means of the sound I unhesitatingly assert that the only legitimate treatment is that by a properly adapted pessary. I protest against the statement of a well-known operator that "the only place for the pessary is the back of the fire." Such a statement can only be the outcome of profound ignorance of the subject. The mania for surgical interference which characterises the present-day gynæcology, the ignorance prevailing with regard to the principles of the treatment by the pessary, and the want of skill in its application, have blinded men to the justice of this simple proposition which I have laid down, and we read of hundreds of cases of operation by individual operators, such as shortening the round ligaments from without or from within the peritoneal cavity, ventro-fixation and vagino-fixation. If I could have brought my conscience to the point of persuading my patients to submit to any one of these operations, I also should have been able to reckon them by hundreds. But I have never done so. Alexander's operation never appealed to me because of the fact that when the uterus is pulled down the last structures put on the stretch are the round ligaments, while ventro-fixation placed the uterus in an unnatural position, and vagino-fixation appeared to me an outrage on common sense. On the contrary, there is no branch of my work that gives me more satisfaction than the use of the pessary in cases of uncomplicated retroversion of the uterus, and for these reasons, viz.: the absolute *absence* of danger, the relief which it gives in all cases when properly applied, and the prospect of cure in a large majority of the cases. It is no valid argument against its use that the pessary has to be worn for many years. The same objection may be urged against the wearing of a set of artificial teeth, and with much more justice.

The time required to effect a cure will be in proportion to the duration of the displacement. Striking examples establishing this proposition are afforded by the cases of recent occurrence to which I have already referred, viz., from falls, and in which relief was immediately obtained and a cure effected within a year, as well as in the following case very briefly related. A former patient of mine (1890) was cured of uterine congestion, and a year after the cessation of treatment bore her first child, after having been sterile for four years. After several years of widowhood she married again, and being desirous of having at least one child more, for her husband's sake, again sought my aid in January, 1896. The uterus was in perfect position and free from congestion, but the cervix was hard and the canal contracted. Under a course of treatment by graduated bougies the canal became patulous, and in due time she became pregnant. She had a very good confinement, but immediately on getting up she began to suffer great discomfort and even pain in the pelvic region. An appeal to her medical attendant was without avail, and as soon as she could travel she came to town. Examination revealed a well-marked retroversion. The application of a pessary gave her immediate relief, and in a year I removed it. Six months afterwards the uterus was in perfect position.

The majority of my patients come after many years of suffering, some—I may say most—of them having worn pessaries (up to as many as seven) of various kinds and sizes, others only subjected to medicinal treatment. I have a large number of pessaries duly labelled, as examples of completely successful treatment, *i.e.*, cure; but I have, or have had till recently, a very much larger number illustrating unsuccessful treatment, removed from patients to whom I have been able to afford relief. These examples illustrate the ignorance prevailing with regard to the principles of treatment. To say that a man who puts a pessary into a woman's vagina merely because she has symptoms referable to the pelvic region is ignorant of first principles is a self-evident proposition. And yet how many of these cases have I seen! Given a genuine case of retroversion it is necessary to understand the principles of treatment. In all cases of retroversion there is a certain amount of descent of the uterus. In a well-marked case the cervix will be found close up behind the pubes, in the axis of the vagina, with the os pointing to the outlet, so that the examining finger passes straight into it (if dilated). In extreme cases the os even points upwards as the patient lies on the back. The vagina is shortened in proportion to the amount of descent. The first principle, then, is to restore the uterus to its normal position, and despite all that has been said against the use of the sound, I maintain that it is the best means for this purpose. In a few cases, when the abdominal walls are very thin and lax, it may be possible to effect the restoration by



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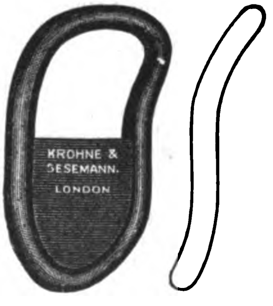
the bimanual method, but even in these the proceeding gives much more pain than the sound. By means of this instrument the uterus can be raised till the fundus touches the anterior abdominal walls without the possibility of injury, provided the cervix be supported by the finger guiding the sound. For this purpose the sound should be well bent, not curved near the point as is usual, but as in illustration (p. 50). In all cases it is essential that the bladder should be empty. Then the sound is withdrawn, and, while the cervix is pressed backwards and the fundus forwards, the intestines are pushed well down behind the uterus, and the organ is left in a state of exaggerated anteversion. The pessary is now applied, and if the sound again pass in the normal direction we have proof that the normal position is maintained- I may here add that this exaggerated position of anteversion has never, in my experience, caused any symptoms.

While it is of the first importance that the uterus be thus placed in its proper position, it is equally necessary that the form of the vagina should receive our attention. The restoration of the uterus to its proper position restores the vagina more or less to its normal length. Now the object of the pessary must be to maintain these two effects. The mode of action of the pessary has been so often described by Goodell, Schultze, and others besides myself, that I need not dwell upon this part of the subject. To put in a pessary without first restoring the uterus to its proper position, in the hope that it will effect that object, has been sufficiently condemned by other writers. Schultze is very emphatic on this point, for he says "no pessary in existence can do this; the normal position must first be restored."

Now it must be remembered that the vagina is a collapsed tube—not an open tube or pipe as authors continually represent it even at the present day—flattened antero-posteriorly, with the two surfaces in close apposition and closely embracing the cervix. This is admirably illustrated by Hart and Barbour. Therefore it follows that any instrument which separates these surfaces to that extent distorts the vagina. Hence also it follows that as it is not possible to devise an instrument that will obviate this entirely, the best is that which distorts it the least. The forms (and names) of the pessaries that are now, or have been in use, are legion, and while much ingenuity is shown in their construction, very little judgment is exhibited. Careful investigation has shown that the form of the vagina may be represented by a thin section through the middle of a pear, the stem end being towards the vulva.

The instrument then which most nearly meets the requirements of the case is the Albert Smith modification of Hodge's pessary, than which I do not believe it possible to devise a better, and when made of material that can be readily moulded to suit the necessities of each case we have all that we can desire. The figure-of-eight pessary has these disadvantages, that if the cervix be enlarged, as it frequently is, it gets strangulated in the posterior opening, and the walls of the vagina are kept too far apart, where the limbs cross one another favouring the accumulation of discharge. This applies to all the others in varying degree. I think I am justified in calling the "ring" pessary the "abomination of abominations." Yet I am told that it is sold by the gross where all other varieties are sold by tens. From its tendency to resume its circular form the effect of this instrument is to shorten the vagina, and thereby continue the descent of the uterus, and to keep the naturally opposing surface widely asunder, &c. Hence we need not be surprised that the men who use this instrument never meet with a case of cure, and therefore form a low estimate of the value of the pessary. It is *impossible for a ring pessary to cure* a simple case of retroversion. Until recently I had a very large collection of these pessaries ranging in size from the smallest to 4½ inches in diameter. Their removal was always attended with the escape of a more or less copious discharge, often offensive. I am surprised to find that this form still finds favour with the writers of the two papers I have referred to at the beginning. Under the same condemnation comes Fowler's pessary, and if it be possible to pass a heavier sentence I select the cup-and-stem pessary for it. I have quite recently come across two cases in which this instrument caused intolerable suffering. In one of these only was there any displacement, and in this case the application of a properly fitting Albert Smith-Hodge gave immediate relief, notwithstanding intense uterine congestion.

If ignorance of first principles be answerable for much of the failure to afford relief, or effect a cure by the adaptation of a pessary, want of skill is no less so. From a combination of the two it results that the pessary is often put in doubly reversed, with the infliction of much unnecessary pain. This had so frequently occurred in the case of patients coming from the country that, some years ago, I had to resolve that unless the patient could give me the opportunity of ascertaining the cause of any failure to give relief, I would not undertake the case. Quite recently the breaking of this resolution was attended with distressing circumstances. The patient was a young woman, the mother of one child. She had not been well since the birth of that child, six years ago, suffering from more or less constant pain in the pelvic region, from menorrhagia (for which she had been twice curetted), from dysmenorrhœa, headache, sleeplessness, thoughts of suicide and gastro-intestinal troubles, including obstinate constipation. The application of a cup and stem caused her intolerable suffering, and she was at last told that she must make up her mind to be an invalid for the rest of her life. It was under these circumstances that she consulted me. Examination revealed the existence of retroversion, with general enlargement—probably sub-involution—intense livid congestion of the enlarged cervix, and "erosion" of the circle of the os. After a course of treatment, including the use of a pessary, she had improved so much in every respect, and the uterus was in such excellent position that on one occasion I sent her home without the pessary—as a test. Three days afterwards she began to have her old symptoms, and at her request, though with some misgiving, I sent her the pessary. A great deal of pain was inflicted upon her in the effort to introduce the pessary by means of a speculum, and otherwise. After its introduction not only was there no relief but an actual aggravation of the symptoms. In a state of despair she telephoned to me her condition, and I had to ask her to come up at once—a distance of nearly 200 miles. I found the pessary doubly reversed. Its re-application, without any pain, at once relieved her, and now, unconscious even of its presence, she looks to the future with confidence.



The authors of the papers referred to are, as I have said, still in favour of the ring pessary. The former actually gives an illustration of an impossible state of things with the ring *in situ*; and the latter specifically says, that "in uncomplicated cases of cystocele *and rectocele* a rubber ring pessary usually answers best, whether there be cystocele alone, a rectocele alone, or a combination of the two." I may at once say that a pessary applicable to the treatment of a rectocele has not yet been devised, nor is likely to be, and the only effectual treatment is the restoration of the perineum. It is quite different, however, in the case of cystocele. For this condition we have a perfect support in the diaphragm pessary, which was introduced to the notice of the profession many years ago in my little book, but which appears to have been overlooked. Here is an illustration.

With this instrument I have obtained excellent results in cases of cystocele and elongated cervix. In one case of the latter in which the cervix had passed through the vulva, a lasting cure was effected. The only difficulty attending its use is that it cannot be kept in stock, and a model has first to be made out of a Britannia metal pessary with elastic bands across. From this model one is made of vulcanite.

There is a general agreement as to the precautions that should be observed in the use of pessaries. That they are not in every case attended to ought not to be charged against their use, but against their abuse. If these precautions were observed we should not hear of "injuries due to neglected pessaries."

As far as present appearances show it seems hopeless to expect that the age of anteversion pessaries will soon be at an end, or of vaginal pessaries for anteflexion. Yet a moment's consideration of the anatomy of the parts ought to convince any unprejudiced mind that it is impossible to influence for good either of these conditions. Thus anteversion beyond the normal will be due to something behind the uterus pushing it forward, and in such a case the anteversion claims no attention. Anteflexion is in no way influenced by the frequent distension of the bladder, and it is an utter impossibility to exert any pressure on the fundus owing to the intervention of that viscus. As I have already said, anteflexion is not a displacement but a malformation, and must be treated from within. For this purpose the intra-uterine stem—preferably Meadow's combined stem—is often of great service. But seeing that anteflexion *per se* is not necessarily a cause of symptoms until it becomes associated with some degree of obstruction to the escape of the menstrual flow through narrowing of the canal, this instrument now seldom finds a place in my armamentarium. This narrowing of the canal may be only temporary, that is to say during the physiological congestion which characterises the menstrual period, or may be permanent through hyperplasia of the uterine tissue, in which case the internal os will be found to be extremely rigid, so much so as to resist the distensile action of a large laminaria tent for forty-eight hours. Such a tent I have illustrated in my book—and I have seen many of them when dilating for the purpose of curetting. In these cases the process of dilatation is often accompanied by retching or even vomiting, as it is in the use of graduated bougies. These cases are not suitable for the stem pessary, but for gradual dilatation. Did time permit I could give some striking examples of this effect, and I may now state that I have long given up any cutting operation in their treatment.

When it is said that "at their worst pessaries are capable of producing serious injuries and at their best they have inherent drawbacks," I would ask of what method of treatment cannot the equivalent be said, and with far more justice? The writer of these words has drawn up the following indictment against them, viz., "that there is a tendency to set up irritation resulting in constant leucorrhœa (*which I deny*), and entailing the necessity for regular douching; there is the necessity for examination at more or less frequent intervals (*to which I give a qualified denial*), which most women naturally find objectionable (*yes, when, as I have heard, some men are in the habit of removing the pessary for every menstrual period*), there is the uncertainty of results, and, lastly, in favourable cases there is the prospect of a woman having to wear a pessary for ten, fifteen, or twenty years." Apart from the fact that this indictment shows a lamentable want of appreciation—to put it, in the mildest way—of the proper use of the pessary, how does this indictment compare with that which can be brought against his "more excellent way," viz., either of the various operations which have been devised, and are now so frequently resorted to for the relief of uncomplicated retroversion? I refer you to the recent report of Professor Oui, read before the recent Congress of Gynæcologists at Rouen, on the influence of these operations on pregnancy alone.

Now, I am not aware that there is on record a single case in which a woman has lost her life through the use, or even the abuse, of a vaginal pessary. On the other hand, what a tale of disaster could be written with regard to the operations I have referred to! Failure in every respect has attended them; immediate failure by death of the patient; failure to effect a cure, or relieve the symptoms; abortion as the result of the imprisonment of the uterus; rupture of the uterus through the same cause; the necessity for Cæsarean section in the cases of women who have previously had normal confinements, and in a considerable number of cases return of the displacement after a succeeding pregnancy; and finally the need of a second operation to remove the effects of the first. Do not suppose that I am drawing upon my imagination for all this. It is all too true. I say that an operation which is certainly not one of necessity, which cannot even be said to be one of expediency, which involves so much risk of life and actual disaster, and which places the uterus in an *unnatural position* is not a justifiable one. At least that is the opinion I have long held, and now with increased tenacity in view of extended results; for my estimate of the sanctity of life has prevented me from adopting the practice even in a single case, seeing that I have been able in a vast majority of cases to afford relief by a perfectly harmless procedure. Some of these operations have already been rejected, notably Mackenrodt's operation of vagino-fixation—an example of "the remedy being worse than the disease"—and each individual operator declaims against the methods of the other.

When a retroversion is complicated by adhesions, inflammatory states of the appendages, or tumour in the uterine wall, it is not the version that calls for treatment, but the complicating condition. Yet I have seen a considerable number of complicated cases in which I have met with unexpected and most gratifying success from the use of the pessary. Did time permit, I could give details of a case of retroversion complicated by a fibroid tumour of small dimensions, just short of being imprisoned in the pelvis, in which a pessary retained the uterus in position until the disappearance of the tumour coincident with the menopause left the uterus in its normal place. This patient wore the same pessary (Britannia metal) throughout. Had this patient any reason to complain of having had to wear a pessary for more than ten years? I trow not.

The pessary is an important aid in the treatment of sub-involution so often associated with, if not due to, the retroversion. In the case of retroflexion properly so called, or as I have defined it, no vaginal pessary can be of any service in undoing the flexion, for the reason that it is impossible to afford direct support to the fundus by its means. In these cases, which, by the way, are very rare, the instrument I use is Meadow's compound stem, and it is remarkable that menorrhagia, which so frequently accompanies this condition, is not only not aggravated, but actually benefited by it. That many cases of retroversion of long standing have some amount of flexion super-added is unquestionable, from long-continued intra-abdominal pressure on the anterior surface. But these are essentially retroversions. This posterior flexion appears to me to constitute a strong argument against the current doctrine that anteflexion is the normal form of the uterus. In a case of true retroflexion a vaginal pessary simply aggravates the flexion by doubling the uterus still further upon itself.

Now arises the question, of what material should the pessary be made? The rubber or celluloid-covered wire, the vulcanite, and Britannia metal, all find their advocates. The pessaries I have had to remove most frequently and accompanied by the most offensive discharge have been the first-named. The idea of putting a cushion on the posterior crossbar, filled with air or glycerine, to support the fundus not only shows an ignorance of the action of the pessary, but is a physical mistake; for, in a short time, the cushion collapses and presents a horribly corrugated surface, with what result I need not describe. I am informed that these cushions are now filled with gelatine, but that does not alter the principle. The vulcanite is open to only one objection, viz., that it is very difficult to alter the shape, and, as Marion Sims said, "the man who is not a mechanic should not trust himself to use a pessary." I have tried the celluloid, which finds so much favour with Schultze and his followers, but others as well as myself have found that it does not retain its shape unless nearly straight. The most suitable and convenient material, according to my experience, now extending over a period of about forty years, is the Britannia or white metal. The shape is most readily altered, and is retained, and the metal itself offers this advantage—that it gives notice of the presence of any irritating muco-purulent discharge, by becoming more or less black. It is also very easily cleaned and polished, and can be worn for years. Were it not for the difficulty of moulding it the best material of all would be aluminium on account of its extreme lightness and non-liability to corrosion by any discharge. But this difficulty and the cost militate against its more general use.

I have now shown that the pessary when properly used, and not abused, involves no danger whatever, but is worthy of our full confidence, that the charges that have been brought against it cannot be justly sustained; that in its results it compares most favourably with the operations which have been substituted for it, and that it is an entire misrepresentation of the case to say that "the operative measures" to which I have referred "do all and more than all that pessaries can do without their manifold drawbacks and risks."

If I had done nothing more than afford the relief which the pessary has enabled me to give I should now feel that my professional life had not been ill-spent, and if I have failed in some cases I have at least the satisfaction of having done no harm. I may have used some strong expressions in the course of this communication. If I have done so it has been from a sense of duty, and if I had a hundred tongues I should use them for the purpose of trying at the least to put a curb upon the frequency with which the operations to which I have referred are performed.

THE URINE SEPARATOR OF LUYS. (*a*)

By FRANCIS M. CAIRD, M.B.Ed., F.R.C.S.,
Assistant Surgeon to the Edinburgh Royal Infirmary; Lecturer on Surgery, Edinburgh Medical School.

The instrument had been introduced only a comparatively few months ago, but it had already shown itself to be a valuable addition to our armamentarium in all genito-urinary cases in which it was important to ascertain how each of the kidneys was functioning. The instrument in its approved form consisted of the following parts, and in order to get trustworthy results it was essential that it should be properly constructed. In shape it resembled an old-fashioned catheter with a straight shank and a sickle-shaped extremity. It was the size of a No. 4 bougie, and in using it one essential point was to ensure that the whole of the curved part was completely in the bladder. The instrument consisted first of a metal rod, curved as described, and having attached to its point a fine chain which lay along its concave aspect, and terminated by being affixed to a screw on the handle of the instrument. The rod and chain were enclosed in a thin rubber cover. On each side of the rubber-clad rod and chain there was a catheter, semicircular on section, the flat side being apposed to the rod. The two catheters and the rod and chain were arranged so that their points fitted into a rounded thimble, which held all three together, and converted them, as it were, into a single bougie. By tightening up the screw to which the chain was attached, the latter, of course, formed an arc to the circle composed by the curved rod, and in doing so drew up the elastic covering so as to form a diaphragm filling up the sickle-shaped concavity of the rod between the two lateral catheters, and thus forming a partition between them. The instrument was used as follows:—After washing out the bladder and leaving in it a few ounces of sterile salt solution, the separator was passed like an ordinary catheter. Any difficulty which might be experienced could be got over by putting a finger in the rectum or vagina to guide it, and at the same time to make sure that it was really in the bladder. As soon as it was *in situ*, the patient was raised into the semi-recumbent position, the thighs were separated, and the handle of the instrument was steadily held *exactly in the middle line*. Then the salt solution in the bladder was allowed to escape by the catheters, whereupon the bladder contracted down on the separator, which was lying exactly between the two urethral orifices. By tightening the screw and so raising the chain with its rubber diaphragm, the bladder was then divided into two practically water-tight compartments, into each of which a ureter opened. Then on the separator was hung a frame containing two test tubes, one below the mouth of each catheter, and into these the urine from each kidney was separately collected. A good test of renal adequacy was supplied by the intra-muscular injection of a three per cent. solution of indigo-carmine, which under normal circumstances, was excreted by the kidney about ten minutes after its introduction into the circulation, while if the kidneys were diseased the blue colour was not communicated to the urine for several hours. Besides this test, the urine from the two kidneys should be compared as to reaction, bacterial content, specific gravity, urea, freezing point, &c. A number of case records illustrating the use of the separator were read, diagrams of the tubes of urine from each kidney being shown. It was shown that the use of the separator had led to the affected kidney being removed in a case of tuberculous disease in which the right organ was enlarged and tender. The urine from the right ureter, however, being normal, while that from the left was scanty and not discoloured by indigo-carmine, showed that the left kidney was the diseased one; it was removed, and at the same time the enlargement of the right kidney was found to be due to compensatory hypertrophy. In such a case as this, to have been guided by the clinical examination only would have been to court disaster. In other cases a separate examination of the urine from each kidney had either allowed of the extirpation of the affected organ, or by showing that neither kidney was adequate had prevented rash and unnecessary operations.

(a) Abstract of Paper read before the Edinburgh Medico-Chirurgical Society, July 5th, 1905. For discussion see page 57.

SOME OF THE LESS COMMONLY RECOGNISED PHENOMENA ASSOCIATED WITH RICKETS.

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OF all diseases met with during infancy, rickets is undoubtedly one of the commonest. The ordinary symptoms are too well-known to need mention here. We are at present more concerned with certain of the less commonly recognised phenomena occurring in the course of this disease. Most of these are, perhaps, somewhat rare, while others which we shall also refer to are exceedingly familiar in the course of everyday practice.

The condition known as "facial irritability" is a very common manifestation of rickets. When we tap with the forefinger over the masseter muscle on either side we obtain a reflex contraction of the muscles of the forehead corresponding to the side of the face tapped. This phenomenon is not always present, but it is one which should be looked for in every case. When it is obtained, it means that the nervous system is affected, and the patient will either be found to have had fits previously, or if not is exceedingly liable to suffer from them on slight provocation in the near future, unless treatment is promptly carried out. As a valuable index, therefore, to therapeutic measures, facial irritability must be carefully kept in mind. Of one hundred consecutive cases of rickets examined we found this phenomenon present seventy-one times.

Laryngismus stridulus is a curious condition occasionally met with. The infant has crowing fits in which the breath seems to stop for an instant, and then relief is obtained by a long-drawn stridulous inspiration. It is simply a reflex spasm of the larynx, and is readily induced by very trivial causes. It is often termed "croup" by the laity, but is seldom serious, although it indicates great instability of the nervous system. Convulsive seizures sometimes follow upon, but more usually alternate with, such attacks. The treatment is essentially that of the underlying condition, namely, rickets. The patient must be properly fed, not on artificial food of all descriptions, but on milk and, if old enough, on oat-flour and eggs, which are rich in fat. In addition, douching of the spine with cold water after the morning bath is excellent as a means of bracing up the nervous system. A valuable aid to treatment is virol, which contains malt, eggs and meat-juice in a highly assimilable form. This may be given in amounts varying from one quarter to one teaspoonful thrice daily according to the age of the patient.

A third rachitic manifestation is tetany; in fact, some authorities regard laryngismus stridulus as merely a suppressed form of tetany. The latter condition is certainly brought about by reflex excitation of the nervous system, but in what way has never been exactly determined. From the fact that gastro-intestinal disturbances are frequently associated with tetany, we were led to the conclusion that probably a careful examination of the abdomen might reveal some causal condition. By auscultatory percussion in a number of cases of infantile tetany, we have made out a considerable degree of gastrectasis. It is a recognised fact that dilatation of the stomach is sometimes associated with tetany in the adult, and we have placed on record (*Practitioner*, December, 1903) a case of gastric carcinoma with well-marked gastrectasia, in which death was preceded by tetany. In view of this we may fairly conclude that tetany and gastrectasia are closely related in early life. The gastric dilatation which occurs in rachitic babies is largely the result of muscular atony, but it is no doubt also partly produced by the improper feeding which underlies the original condition. So far as the treatment of tetany is concerned, we must employ measures which will diminish the spasm. Nothing succeeds so well as the combination of sod. brom. and phenazonum. In addition, cold douching of the spine is a most valuable help. Should the stomach be found to be dilated, lavage may be tried, although in some cases we have found it aggravate the condition. Care should be taken regarding the feeding of the patient. Nothing but milk should be allowed, and only small feeds should be given at regular intervals. Fresh air is requisite also, and accordingly the infant must be taken out every day. The after-treatment should be directed to the removal of the underlying rachitic condition. For this suitable feeding is required just as in laryngismus stridulus.

A curious rachitic condition is that of "head nodding," or spasmus nutans, as it is otherwise termed. The patient's head resembles in its movements those of the toy animals with movable heads, and it either keeps moving from side to side or backwards and forwards, as if it were centred on a pivot. In every case the patient suffers from rickets, but it has been stated that the real source of this phenomenon is want of sunlight. Such infants are said to have been brought up in dark rooms or to have lain in a crib placed in a dark corner of the apartment. This, however, has not been our experience. During the past three or four years we cannot remember seeing a single case in which such a history was obtainable. In fact, on the contrary, one of our best-marked cases was that of a baby whose home we visited personally in order to investigate this particular point. The room was a large one, well lit and facing due south. The child's crib was opposite the window, and the house was scrupulously clean. The rachitic condtion was in this instance induced by the use of an artificial food, which had been given to the infant almost from birth. By stopping this and putting the patient on pure milk, with the additions mentioned later under treatment, a cure was ultimately effected.

Head-nodding is frequently co-existent with another condition known as nystagmus. These two, indeed, almost invariably occur together. Like head-nodding, this is a purely nervous phenomenon, and is induced by the want of tone in the nervous system which rickets sooner or later brings about. No special treatment is necessary beyond that already mentioned. We have known the condition to be very persistent and one case recently under our care had lasted for nearly five months. By the use of cold spinal douching, a suitable dietary and the administration of virol the nystagmus gradually disappeared, as did also the head-nodding, with which it was intimately associated.

Adenoids is probably not a condition which is looked upon by the profession generally as being of rachitic origin. They are very prevalent, however, in rachitic children, so that we incline to the belief that hypertrophy of the lymphoid tissue composing the pharyngeal tonsil may readily be induced in infants affected with rickets. It is now well-known that adenoids are met with during the period of infancy, their presence being sometimes indicated by noisy breathing and difficulty in suckling, while snuffling is by no means uncommon in such cases. The noisy breathing of adenoids has to be distinguished carefully from congenital laryngeal stridor. The latter is present from birth and is not worse at night, while in adenoids this symptom is rarely manifested until after the sixth month, and is always aggravated at night. Adenoids is such a common affection in early life that, relying on the theory of their rachitic origin, we would do well to guard against the occurrence of rickets, and when this disease does make its presence felt, great care should be taken in its treatment.

In rachitic infants, otorrhœa is a very common occurrence. If we examine the tympanic membrane in infants affected with rickets we shall rarely find it absolutely normal. In fact, a catarrhal condition of the ear is but one of the catarrhal states which rickets produces and is akin to the vomiting, diarrhœa, rhinitis, conjunctivitis and bronchitis occurring during the course of this disease, and which are all undoubtedly of similar origin. Accordingly, the treatment, although local to some extent, must be guided by general principles, and in every case careful dieting, fresh air, and the use of virol, or, if preferred, emuls. ol. morrhuæ, must be enjoined.

The following table gives the number of cases presenting one or other of the conditions we have referred to in a consecutive series of one hundred rachitic infants who have been under our care. In some instances more than one condition was manifested by the same patient :—

Facial irritability	71
Otorrhœa	34
Laryngismus stridulus	8
Head-nodding	2
Tetany	3
Nystagmus	2
Adenoids (1 doubtful)	2

These numbers refer to infants. Adenoids induced by infantile rickets usually do not come under medical treatment until the period of childhood is reached.

Regarding the treatment of these and other manifestations of rickets, the following simple rules should be kept in mind :—

1. The diet must in every case be carefully investigated. All forms of artificial food should be stopped. Breast-feeding should not be allowed after the ninth month ; and nothing but milk permitted before that period if the infant is brought up by hand. After the ninth month, oat flour, eggs, gravy, but no starchy food, may be allowed in moderation.

2. Cold douching of the spine should be ordered as a routine measure. It is best given in the morning after the ordinary bath has been taken. If given before the fire with the feet in a little tepid water no chilling effect will be produced.

3. Fat must be supplied in every case. Oatmeal, egg yolk, and cream may be ordered for this purpose. So, too, emulsions of cod-liver oil are invaluable in this connection, while petroleum emulsions; as we have freqeutly pointed out, are absolutely valueless. The latter simply act as lubricants, are not absorbed, and may actually produce vomiting and diarrhœa. During the summer months we prefer virol, which contains a large percentage of fat in a very readily assimilated form. It does not produce gastro-intestinal irritation which cod-liver oil is very apt to do in hot weather. In fact, we are now in the habit of substituting it for cod-liver oil emulsion whenever the warm weather sets in, while in a large number of cases we have prescribed virol from the very first. It is always well tolerated, and its pleasant taste makes it agreeable to infants who readily dislike nauseous drugs. It acts satisfactorily upon nutrition in all rachitic cases, and infants to whom it is given generally show a rapid gain in weight.

These remarks are intended merely to serve as suggestions. They indicate the lines along which treatment must be carried out. In conclusion, too great care cannot be taken to secure the well-being of rachitic patients, as, should acute disease supervene, they lack the necessary resisting power, and not infrequently succumb to what would, in a normal healthy infant, prove to be merely a slight illness. Moreover, chronic bronchial catarrh induced by rickets leads to permanent deformity of the chest, which may prove of serious import in later life. These are but some of the reasons why the treatment of rickets is always a matter of extreme importance. To the thoughtful physician others of no less consequence will doubtless suggest themselves.

French Clinical Lectures.

STRICTURE OF THE ŒSOPHAGUS.

By A. VINCENT, M.D.
Professor of Surgery at the Medical School of Algiers.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

Here is a man who comes to us complaining of a difficulty in swallowing. He first noticed it some four months since, and then it only occurred at certain times, or on endeavouring to swallow particular articles of food, especially meat, that he constantly felt a hitch at a point behind the manubrium sternum. He first attributed it to indigestion, and this view, he tells us, was confirmed by several medical men whom he consulted. Try as he would to explain it away, as of no particular importance, the difficulty steadily increased, until he was obliged to nourish himself exclusively on slops, for he could still swallow liquids with tolerable ease. At the same time, possibly in consequence of his change of dietetic habits, he lost weight. From being a stalwart man with a tendency to obesity, weighing in fact some 84 kilogrammes, he now only weighs 69 kilogrammes, so that in the last four months he has lost some 15 kilogrammes, a rather alarming reduction. Of course, the loss of flesh may or may not be due to the fact that he has not been able to take the usual amount of food, but in any case his inability to partake of meat must be accorded a share in its causation.

He tells us that the difficulty consists in a feeling of constriction at the lower part of the œsophagus on swallowing, not exactly a pain, but merely a feeling that the food " sticks in his gizzard " so to speak. He denies ever having vomited or regurgitated food after a certain lapse of time (which would indicate the presence of a pouch), and he says he has never brought up any blood.

You will note that he appears to be a healthy man, and fairly robust, though his face bears traces of the anxiety which no doubt he feels at being obliged to come to the hospital for relief. Like so many of our patients he greatly desires to be relieved, but he almost as strongly resents the idea of any surgical intervention and, as you are aware, we surgeons are often suspected of a desire to operate, apparently for experimental purposes, whenever we get a chance. His complexion is of a healthy tint, he is hardly what you would call emaciated, in spite of his loss of flesh, and he is still, from a muscular point of view, reasonably strong. He has always been a man of active habits and has no doubt lived well, an expression that covers a multitude of dietetic irregularities.

The question we have to decide, in the interests of both prognosis and treatment, is as to the cause of this stricture of the œsophagus. He himself, apparently inclines to the view that it may have something to do with his past venereal history. He denies having had syphilis, but he admits having, on two different occasons, had a sore or chancre, the last some eighteen years ago. So far as he is aware the lesion was of the nature of a soft chancre on both occasions, in any case the first was not followed by any constitutional symptoms and healed after a two or three weeks local treatment. Some six weeks after the second, however he had an eruption of some kind, which " he is sure " was not syphilitic. As he presents no trace of specific cutaneous lesions we must leave this question unanswered and in any case syphilitic strictures of the œsophagus are of extremely rare occurrence.

We will now proceed to pass an œsophageal bougie. You will note that I am careful to commence with the largest size. This is a highly important detail, because if you begin with a small bougie you may catch the point in a fold of mucous membrane and be led to diagnose the presence of a stricture which has no existence. Only the other day I was called in consultation not far from Algiers in the case of a woman who had for some time suffered from symptoms suggestive of stricture of the œsophagus. The doctor in attendance had done his best to make sure of his diagnosis. He had introduced a small bougie, but was unable to reach the stomach, it being arrested some three inches from the cardiac orifice. I repeated the manœuvre, but, in accordance with the principle that I have just laid down, I used the largest size, and it passed into the stomach without the slightest difficulty, rather to the doctor's confusion.

You see that the bougie I am using becomes impacted at a distance of, roughly speaking, eleven inches from the teeth. Attempts with the smaller sizes prove equally unsuccessful in reaching the stomach so that we can have no doubt as to the existence of a genuine narrowing of the œsophagus —a narrowing which, indeed, has reached a serious degree of stricture.

You will agree with me when I tell the patient that the stricture *may*, after all, be syphilitic and *may* yield to medical treatment, though I cannot absolutely promise that he will recover the power to swallow in its integrity.

Now that the patient has left the room we are at liberty to discuss the nature of the stricture more freely. You must not take seriously what I told the patient, because it is our duty always to encourage hope, the more so as in this instance it is probably all that is left to him. I have little doubt, in view of the circumstances, that the stricture is due to a malignant growth, a neoplasm as it is conveniently called, for the terrible word cancer is one which we must accustom ourselves never to use except between ourselves. I venture to tell him that it will be necessary, or at any rate desirable, in order to enable him to take a proper amount of nourishment, to make an opening into the stomach. Gastrostomy is an operation practically devoid of risk, and it will have for immediate effect the improvement of his general health. He will put on weight and imagine that he is getting well. Alas ! if my diagnosis be correct the improvement will only be temporary, for the disease will pursue its course and ultimately cause death in the usual way. Nevertheless we shall have rendered him a signal service since his end will be peaceful and he will be spared the terrible sufferings of death from gradual inanition. That is something to be grateful for and unfortunately, it is all that we can do for him, the growth not being in a situation which allows of our obtaining access there to, for the purpose of a radical removal by operation.

Of course the victim of stricture of the œsophagus is deprived of the pleasure of eating, a deprivation of which one does not suspect the importance until one undergoes the ordeal. It is so necessary that we should eat that Nature has made the act a pleasure, consequently we do not eat merely because we are hungry, but partly because the flavour of the aliments is agreeable *per se*. After a time, the monotony of absorbing nourishment without the privilege of masticating and swallowing it, engenders marked depression of spirits, but this can be obviated by allowing the patient to masticate some of the food he is taking, not of course attempting to swallow it, but merely for the purpose of gratifying his gastronomic propensities.

I have not dwelt at any length on the differential diagnosis of stricture of the œsophagus in this case, for the simple reason that in a man of his age and in the absence of any obvious cause of injury from within or pressure from without, such strictures are practically always due to neoplastic thickening of the œsophageal wall. Whether malignant or not, gastrostomy is indicated if only to give the parts rest. The constant and ineffectual attempts to swallow solid food set up, or increase, the local irritation and *pro tanto* tend to agrravate the stricture. This course is doubly urgent when we suspect malignancy, because tissue that is undergoing cancerous degeneration is very friable and is therefore easily injured, in which event we get inflammatory phenomena superadded to the existing lesion.

I do not really suppose that his syphilis— for there can be little doubt that his second chancre was syphilitic—has anything to do with his œsophageal lesion except that this disease seems, in a sense, to prepare the soil for cancerous degeneration. Of course, in the present state of our knowledge, we should not be justified in asserting that syphilis caused cancer, but it certainly appears to prepare the way, to make the tissues more vulnerable thereto, and this is indeed only what we should expect when we remember what a profound constitutional morbid influence syphilis brings to bear.

Transactions of Societies.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held July 5th, 1905.

Professor Chiene, C.B., in the Chair.

Dr. Allan Jamieson showed a case of granuloma rubra nasi.

Dr. G. A. Gibson showed two cases of syringomyelia, one of three years' duration, which began with the appearance of blisters on the fingers and arms and difficulty in executing fine movements with the fingers, and now presented dissociated anæsthesia (there being anæsthesia to touch over the areas of the 8th cervical and 1st dorsal root on the right side, and the 2nd, 3rd, and 4th dorsal roots on the left, while analgesia extended over the region supplied by the nine upper dorsal roots), wasting of the small muscles of the hands, and an extensor plantar response. The other was of short duration; there was no tactile anæsthesia, but there was left hemianæsthesia to pain and temperature. In the differential diagnosis, hysteria was excluded by the plantar reflex being of the extensor type on the left side, and by the presence of paralysis of the left cervical sympathetic.

Mr. Cotterill showed a man, æt. 36, who had consulted him six months previously on account of a tumour of the side of the face of three months' duration. The tumour was in the parotid region, and as it was giving rise to great pain and was associated with exophthalmos, a diagnosis of sarcoma in the spheno-maxillary fossa was come to. Treatment with X-rays failing to benefit, the patient was discharged as incurable. He had recently returned, however, and as the tumour had grown no larger the diagnosis had required revision, and now lay between tubercle and a parotid growth of some kind. (2) A case of perforating ulcer of the right foot, associated with abolition of the knee-jerk and anæsthesia on that side, due evidently to a peripheral neuritis, there being no signs of locomotor ataxia. The ordinary statement that perforating ulcer healed with difficulty was contradicted by this case, for, although the subjacent joint was destroyed and its cartilages eroded (a condition which would have rendered the healing of any ordinary ulcer more than problematical), simple application of boric dressings had brought about rapid cicatrisation. In treating these perforating ulcers the important point was to prevent a downward funnel-shaped growth of epithelium round the edges; if this were done they would be found to heal readily enough.

Mr. C. W. Cathcart showed (1) a patient after wiring a recent fracture of the femur on account of malposition, and (2) a patient who had had a very extensive depressed fracture of the skull, which had been successfully elevated.

Mr. J. W. Struthers showed (1) an elderly man after radical cure of a double inguinal hernia by Bassini's method. The operation had been done under local anæsthesia with perfectly satisfactory results, as the patient had continued at his work as a labourer for a year without any sign of recurrence. (2) A patient after excision of the astragalus for compound subastragaloid dislocation of the ankle.

Mr. J. M. Cotterill showed (1) a series of gallstones, and (2) a series of damaged semilunar cartilages removed from the knee-joint.

Mr. Alexis Thomson showed (1) specimens from a case of cholecystectomy for gall-stones and pendulous gall-bladder. (2) Enlarged prostate vesical and calculus removed by suprapubic operation.

Dr. Michael Dewar read a paper on

THE RECENT EPIDEMIC OF INFLUENZA.

Introducing his remarks by a brief historical sketch of the malady, he alluded to the epidemic of thirty years ago, which was of so benign a type, and so slightly fatal, that his teacher, the late Professor Laycock, passed by the disease in his lecture with only a word or two. Of the three recent epidemics, that of 1889-90 chiefly affected the nervous system, and left behind it prostration, mental depression, and again nervous disease; many of those who suffered were never the same again, and not a few died within a year or two. Next came the epidemic of 1898, in which elderly people suffered most, while children escaped. The symptoms were chiefly referable to the cardiac and respiratory systems. Finally there had been the epidemic of the present year, which was the subject of his remarks. In his practice he had had about fifty cases of genuine influenza, excluding ordinary febrile catarrh. These began about the middle of January, and declined about the middle of February, reaching their maximum about January 31st. He depended for diagnosis on excluding all other diseases, the only other test being the bacteriological recognition of the bacillus in the sputum, which was not always a practicable matter. True influenza, due to Pfeiffer's bacillus, must be distinguished from the milder disease, grippe, which bore the same relation to the former as cholera nostras did to Asiatic cholera, its cause being quite unknown. Influenza was of three types, a cardio-pulmonary, a gastro-intestinal, and a nervous variety. The features of the first were high fever for the first two days, then a lower temperature, and a return to normal during the second week. There were either bronchial or cardiac symptoms, and adults of both sexes, as well as children, were equally affected. The gastro-intestinal cases generally occurred among children and male adults; pain in the right hypochondrium and below the right shoulder was a very constant symptom. In cases in which the nervous system was chiefly affected the temperature was low, and soon fell to subnormal, where it remained for a week or more, accompanied by a slow, feeble pulse, before the usual level was reached. A number of illustrative cases were read, including some showing both pulmonary, gastro-intestinal, and nervous symptoms. Speaking of treatment, Dr. Dewar related his own methods, but laid stress mainly on nursing. He concluded by pointing out that influenza tended to occur in epidemics at intervals of seven or eight years, and that each lasted for six or eight weeks. In gastro-intestinal cases the special form of pain he mentioned —in the right hypochondrium and below the right shoulder was a very constant symptom. Coryza, on the other hand, was often absent.

Dr. Ritchie discussed the paper, agreeing that the last epidemic had been a comparatively mild one. He always employed stimulants, such as camphor, nux vomica, or alcohol, from the very onset, and never gave antipyretics. Headache was usually due to frontal sinus catarrh, and was best treated by hot applications. He deprecated calling every trifling feverish catarrh an attack of influenza.

Mr. F. M. Caird read a paper on

THE URINE SEPARATOR OF LUYS,

an abstract of which will be found on page 53.

In discussing the paper, **Mr. Cathcart** spoke ofthe difficulty he had experienced in introducing the instrument in women on account of uterine enlargement or displacement. He preferred to precede the separator by cystoscopy, and had not found that the introduction of the former was attended by so little discomfort as in Mr. Caird's hands.

Mr. Walliace had found that in cases of prostatic enlargement it was sometimes very difficult to introduce the separator. He agreed that it was a safer appliance than the urethral catheter, though those who had employed the latter and acquired the necessary manual dexterity preferred it to Luys' instrument.

Dr. T. D. Luke read

REMARKS ON POST-ANÆSTHETIC SICKNESS.

Post-anæsthetic sickness was often the most trying sequel of an operation, its occurrence was influenced by the nature of the anæsthetic, the nature of the operation, the mode of administering the anæsthetic, the thoroughness with which the patient was prepared, and the physical condition, age, sex, and temperament of the patient. Sickness was most frequent after ether inhalation, but more severe and lasting after the administration of chloroform. Special mixtures had no special effect one way or another in causing sickness. It occurred after ethyl-chloride in only about 15 per cent. of cases—less frequently, that is, than after any other anæsthetic except nitrous oxide. Drug treatment of anæsthetic sickness was palliative. In certain cases washing out the stomach was of value, but the main indication was to favour the elimination of chloroform from the body tissues in every way.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held Friday, July 7th, 1905.

Mr. John Tweedy, P.R.C.S., President, in the Chair.

Mr. R. R. Cruise described a case of

MICRO-OPHTHALMIC CYST OF THE ORBIT.

The patient, æt. 24, from birth had had a swelling in her left orbit which had been increasing in size for the last two years. There was a small degenerated looking micro-ophthalmic eye pushed into the upper and outer quadrant of the left orbit. The rest was filled with a fleshy mass which was firm and fluctuating. There was a coloboma of the iris, lens, and choroid in the right eye. The left orbital contents which was cystic was removed. On examination the sclerotic was deficient in its posterior half, and through this the retina protruded into the cyst. The iris was adherent to the cornea in its whole extent. The lens is displaced backwards and held in position by a strong band of fibrous tissue attached partly to the globe and partly to the cyst. The cyst enveloped the globe above, below, and to the nasal side. The microscopical characters and peculiarities of the eye were carefully described and showed various developmental peculiarities, while the choroid had some fine bone developed in it. Clinically the diagnosis was by no means easy, especially the differential diagnosis between it and meningocele. Pathologically the chief peculiarity was the free communication between the eye-ball and the cyst, which allowed the free passage of fluid secreted by the well-developed ciliary body to pass into the cyst, and this led to the increase in size of the cyst for which reason the patient applied for treatment.

Mr. Simeon Snell (Sheffield) gave details of a case of

SYMPATHETIC OPHTHALMITIS

in which normal vision was restored in the exciting and sympathising eye. The patient was a man, æt. 33, whose left eye was wounded on September 8th, 1904, and when seen for the first time eleven days later there was a wound of the cornea extending into the ciliary region with a prolapse of the iris. The prolapse was at once excised, and the eye healed without further trouble. On October 2nd, the right eye was noticed to be red, and five days later there was iritis, and it was then noted as being a severe case of sympathetic ophthalmia. About a month later, the pupil began to act and the eye to whiten. Since then recovery had been perfect and vision is now 6/5 and J1 in each eye. Mr. Snell referred to another similar though less severe case which he had recorded in the *Transactions* for 1883. Mr. Snell recorded also three cases in which sympathetic ophthalmitis had come on after excision of the eyeball. The first was a boy, æt. 10, who had a large wound of the cornea and sclera. Sixteen days later the eye was removed. Three weeks later there was sympathetic ophthalmitis. The disease ran a severe course, and the patient can now, fifteen months after the accident, find his way about and read large print. Another case was a man, æt. 26, whose eye was wounded by a kick which involved the cornea-scleral junction. Sixteen days later the eye was excised. A month later Mr. Snell saw him for the first time, when there was marked sympathetic ophthalmitis in the other eye which had commenced a week before. It was a severe case, and practical blindness resulted. He also referred to another case, that of a girl, æt. about 10, The dates, however, could not be given. He referred to a case he published in the *Transactions* for 1882, in which the disease showed itself thirty-two days after excision and 106 days after the injury. Thus, of these four cases, one was mild and recovered, three were severe, and two of them were totally blind. The Report of the Society's Committee stated that such instances were of a mild form, and that out of thirty cases eighteen completely recovered, three partially, and nine were lost. Mr. Snell also reported a case of a further instance of glioma, in more than one member of the same family. He referred to the paper he read before the Society last year in which he related an instance in which two members of the same family were affected. At that time only three observers had placed cases on record. He now related a further case. The patient was a male child, æt. 3½, and glioma was present in each eye. One eye had been noticed affected a few months after birth, and the other a few months ago. It was then ascertained that the only other child of the parents was a girl born in 1897, who was similarly affected with glioma in both eyes, and which proved fatal. Mr. Snell mentioned the fact that the child whose case he had recorded last year was still alive and well.

Mr. Mayou read a paper on

SECONDARY TUBERCULOSIS OF THE IRIS WITH SPONTANEOUS RUPTURE OF THE LENS CAPSULE.

The patient was a boy, æt. 3, who for some time previously had suffered from tuberculous dactylitis. The eye was inflamed for three weeks before being seen. Masses of tubercle were then seen on the iris which was very much inflamed. Hæmorrhage took place later on into the anterior chamber and the eye was removed. On examination it was found that the iris was adherent to the posterior surface of the cornea and Descemet's membrane was perforated, while thesubstantia propria was infiltrated. The mass on the upper part of the iris was adherent to the cornea and to the anterior and posterior part of the lens capsule and contained giant cells, but no epithelioid cells or tubercle bacilli were seen. The anterior capsule showed a large gap evidently produced by the softening of the tubercle followed by cicatricial contraction. The retina also showed masses of round-cell infiltration similar to that seen on the iris. The chief points of interest were the unusual situation at which the tuberculous mass had invaded the cornea; the spontaneous rupture of the lens capsule; the nature of the exudation in thef retina; and the general tendency towards cicatrisation.

Special Articles.

THE ARMY MEDICAL REPORT.

The Report of the Army Medical Department for the year 1903, which was not issued until a few days ago, forms, as far as its nature permits, most interesting reading, and may be regarded as, on the whole, satisfactory. To criticise, or even refer, to one tithe of the immense amount of statistical material which it contains would be absolutely impossible, and consequently it is necessary to confine ourselves to one or two subjects.

The paragraphs dealing with the recruiting of the Army are at present of great interest owing to the recent investigations into the causes of the supposed physical degeneracy of the nation. Turning to them, we find that the number of recruits inspected during the year was 69,553, of which nearly one-third, or 22,382, were rejected as unfit, and that a further 1,022 were discharged within three months of enlistment, bringing the total number of rejections up to 23,404, or to a ratio of 336·49 per 1000. The highest ratio of rejections per 1,000, it is interesting to note, was afforded by England and Wales, and the lowest by the Colonies, while Scotland and Ireland occupy intermediate positions in the order named. The ratio shows a decided increase as compared with the previous year from all sources, the increase in the case of persons born in Scotland being 56·85 per 1,000. It is a very important fact to note that the greater proportion of candidates offering themselves was derived from the class of labourers and husbandmen, and that this class also yielded the highest percentage of rejections. It is a pity that a little more detailed information is not given concerning these, because, as the Report reads, it would seem that the causes of unfitness were as prevalent among the rural as the urban population, and would therefore be contradictory to many of the results that have lately been obtained by an investigation into the national physique. This fact is even more striking since defective general development accounted for as many as 4,911 of the total rejections, and yet we find that there is an increase among the accepted recruits of men under one hundred pounds weight and under 31 inches chest measurement. As regards the education of the recruits it is curious that an increase of 17 per 1,000 has taken place in those returned as "well educated," and at the same time there has been a decrease of 21 per 1,000 of those able to read and write.

The vaccination statistics show that there has been an all-round slight diminution in those bearing marks of vaccination and derived from the United Kingdom, but this has so far had no ill-effect, as there were only two admissions for small-pox during the year, one at Chatham and the other at Cork, as compared with eleven admissions in 1902. Re-vaccination continues to be actively carried on as proved by the fact that no less than 45,075 were performed during the year. Of these re-vaccinations nearly 40,000 were done on recruits.

As regards enteric fever, we note that there has been a slight decrease in both the number of admissions in the United Kingdom and in the death-rate; the latter is, however, still high, as 28 deaths occurred out of a total of 92 cases. Out of the total number no fewer than 27 cases were admitted from Aldershot. In South Africa there were 1,155 admissions with 138 deaths, the disease accounting for nearly 46 per cent. of the total deaths in the command. Among the special points of importance in this connection are (1) the continued high rate of incidence among men who have just arrived in Africa; (2) that intermittent contamination of the water supply has been shown to occur at Pretoria, rendering necessary universal boiling of the drinking water, even when derived from springs that gave a good analysis; (3) the discovery that an aerated water supplied by one large manufactory contained the *B. coli communis*; (4) renewed evidence of infection being conveyed by flies, as in the outbreak among the Leinster Regiment at Pretoria. This cause is also held to be the most important one in accounting for the considerable increase of enteric fever in the Indian forces, and attempts are being made to eliminate it by greater care in connection with latrines, &c. Before leaving the subject of enteric fever we may say that the report dealing with it in connection with India is one of the most valuable in the whole volume. Its excellence and length prevent us from referring further to it.

The report on malarial fever in India is also most valuable. There has been a considerable decrease in both admission rate and death rate, which we suppose may be partly attributed as in Crete and in the Barbados command to the anti-mosquito measures which have been adopted. On this point, as is well known, there is an acute difference of opinion, but the present statistics at any rate show that more scientific and rational means of prophylaxis are being undertaken and apparently with success.

Innumerable other subjects are worthy of discussion, but we must conclude by referring anyone who desires more information to the volume itself, which forms a fine record of the work done by, and of the scientific abilities of, the members of the Army Medical Service.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 16th, 1905.

TREATMENT OF HYDRARTHROSIS OF THE KNEE.

THE treatment of hydrarthrosis of the knee by hot air was first recommended by Klapp, of Germany, and the apparatus for this purpose is of the most rudimentary kind. A small wooden box and an ordinary paraffin lamp. Both ends of the box are removed and replaced by two cylinders of sheet iron or tin. The leg of the patient is passed through the box, and the ends of the cylinders stuffed with cotton wool around the leg to prevent the escape of the heated air. A hole is made in the side of the box to which is fixed a small tin tube slightly curved, so that the free orifice looks directly downwards, and in which penetrates the glass of the lamp. Another small hole is made in the top of the box to create a draught, in which a thermometer might be adapted. It remains only to light the lamp. The temperature should be about 158° F., and the *seance* lasts from half an hour to one hour, repeated three times a day. M. Antoine recommends a much higher temperature (248° F.), but it is preferable to commence at the lower degree and gradually raise it. Slight massage should follow each *seance*. By this treatment the effusion in the joint is quickly absorbed. Hydrarthrosis of rheumatic origin, however, does not benefit from this method as much as that due to traumatism.

TUBERCULOUS GANGLIA IN CHILDREN.

When the ganglia have not yet suppurated they can be treated locally by compresses of some warm absorbent solution and renewed every three hours

Spirit of camphor, 1oz.
Lead lotion, 2 oz.;

or

Chloride of sodium, 1 oz.,
Water, 1 quart;

or

Tincture of iodine, 15;
Sulphate of magnesia, 4 drachms;
Chloride of sodium, 1 oz.;
Water, 6 ozs.

The compresses will be applied in the daytime, and at night the following ointment:—

Carbonate of ammoniac, 1 drachm;
Camphor, 2 ozs.;
Axunge, 1 oz.

As soon as fluctuation is observed, an exploring pucture should be made and the pus replaced by injections of iodoform and ether (10-100). These injections are repeated every 10 or 15 days.

In case of larger cold abscesses, oxygen water should be injected, after removal of the pus, once a week. The usual medical treatment will not be neglected.

TREATMENT OF CIRRHOSIS OF THE LIVER.

Prof. Huchard recommends the following treatment for cirrhosis of the liver:—

Milk diet continued for a month; a glass of ordinary milk every two hours and one glass of skim milk morning and evening. As medical treatment, sulphate of soda will alternate with calomel. A teaspoonful of sulphate of soda every morning for eight days, replaced the following eight days by half a grain of calomel.

Each evening he recommends a compress of cold water covered with oil silk and cotton-wool, over the hepatic region, and kept on all night. When no albumen is present, which is generally the case, small blisters are applied to the liver every ten days. By their means the meteorism diminishes and the patient expresses himself as distinctly better.

Another method frequently employed is *massage*. It increases the diuresis and helps to remove the ascites.

The following ointment facilitates the manœuvre of massaging :—

Spirit of juniper, 1 drachm ;
Lavender spirit, 1 drachm ;
Lanoline, 5 drachms ;
Vaseline, 5 drachms.

Diuretics have but little effect on the ascites; nevertheless theobromine might be given.

Theobromine, 10 grs. ;
Phosphate of soda, 10 grs. ;
For one wafer.

Three daily, at one hour's interval between each, for three days.

If the liquid continues to increase, in spite of treatment the patient must be tapped, and the operation renewed as frequently as may be necessary.

As to complications, the most frequent is epistaxis, for which the usual treatment is generally sufficient. However, in grave cases, applications of senna and gelatine will be found very serviceable.

Chloride of sodium, 5 grs. ;
Gelatine, 1 to 2 drachms ;
Water, 3 ozs.

Germany.

[From our own correspondent.]

Berlin, July 16th, 1905.

At the Medical Society Hr. Bickel related the result of his experiments on dogs relating to the

Influence of Alkalies and Acids on the Secretory Function of the Stomach.

A fistula was made into the stomach of a dog, and the effects of both alkalies and acids noted. Contrary to the general view, he found that alkalies, and especially bicarbonate of soda, not only reduced the acidity of the stomach, but also restrained or diminished the secretion of gastric juice, either from its paralysing effect on the cells, or through its alkalising action on the blood. Hydrochloric acid increases the secretion of gastric juice, and its effects in this direction lasted a considerable time.

Hr. Ewald suggested that the diminishing action of bicarbonate of soda on the secretion of gastric juice did not require a hypothesis of alkalisation of the blood ; the action was more likely to be a reflex one.

Hr. Senator followed with a paper on

Subcutaneous Injections of Preparations of Iron and Iron and Arsenic.

He said that the subcutaneous incorporation of iron had never yet gained a footing in therapeutics. Recently, however, attention had again been drawn to it on the initiative of Italian physicians. It was to be observed that some easily soluble preparation of iron did not cause that severe pain after injection that had hitherto rendered this method of treatment impracticable. Then the green ammonio-citrate of iron in 10 per cent. solution could be given, commencing with half a syringeful a day, and gradually increasing the dose to a syringeful. If continued for from thirty to forty days cases of chlorosis were said to be cured.

According to his own experiments in the cases of chlorosis and simple anæmias, the method had no advantage over administration by the mouth. It had been stated, as in favour of injection, that the iron was not absorbed through the intestinal canal; this was completely contradicted ; both organic and inorganic preparations of iron were sufficiently absorbed through the intestinal walls. The iron was found deposited with marrow of bones in the spleen and in the liver. (2) It was badly borne, and led to gastric catarrh. That was true for a small proportion of cases ; the gastric catarrh was, however, often a consequence of the existing anæmia, and disappeared after its removal. It was also an old-time rule to remove the disturbance of digestion before beginning the iron treatment (hydrochloric acid). (3) Iron was more readily absorbed from the connective tissue than from the stomach. This, however, was not in favour of the subcutaneous method, but against it. Iron was only given in chronic diseases, whether it was absorbed rather more rapidly was, at the least, indifferent, certainly not an advantage, for iron was a poison that in large doses could produce serious mischief in the organism. No such consequences had been observed when it had been given by the mouth, but they had after subcutaneous injection. (4) It had been stated that patients took iron very unwillingly ; there were now, however, a number of well-tasting iron preparation, and to have an injection made day after day for weeks and months were not among the agreeables of treatment. From the foregoing it followed that the treatment by subcutaneous injection was only suitable in innocent and malignant ulceration of the stomach, in pernicious anæmia, leucæmia, and pseudoleucæmia, where the stomach would not bear medicines, and also, perhaps, in the hæmorrhagic diathesis. He had made use of this form of treatment in about thirty cases such giving an iron-arsenic preparation, and especially the readily-soluble ferr. arsen. ætric. ammon., in order to have the advantage of the arsenic. He had also used the cacodylate of iron. In four cases carefully observed, there was, after some time, a considerable increase in the erythrocytes and of the hæmoglobin. Of course, in the diseases named there was no question of recovery.

Hr. Frank had used it with good reuslts in eight cases of chlorosis and anæmia. He had used the ferr. cacodyl. The great pain observed after subcutaneous injection was not present nor the garlicky smell.

Hr. Ewald had had good results from using iron in suppositories. He gave up ferrum lacodylicum on account of ifs fearluf garlicky smell.

Hr. Senator also rejected the cacodyle preparation for subcutaneous injection, both on account of its great painfulness and its garlicky odour. He had not injected iron into the veins, fearing a possible clotting of the blood.

At the Society of Charitée Physicians, Hr. Heubner showed a case of

Obliterating Pericarditis.

This disease, in fatal cases of articular rheumatism in childhood was the one that was the cause of death. During late years all the children dying in his wards of acute articular rheumatism (seven in number) had obliterating pericarditis. It either developed some weeks after the rheumatism had ceased, progressed slowly, was often complicated with pleurisy, and led frequently and unexpectedly to cardiac weakness and death or the commencement of the course was so hidden that the disease was first recognised at the autopsy. A third, also obliterating form, was the tuberculous. Of importance in difficult diagnosis was the striking influencing of the pulse by the breathing as a " feathering " of the wall of the thorax (demonstration) at each diastole. Possibly the operation of cardiolysis would be of value.

Austria.

[From our own correspondent.]

Vienna, July 16th, 1905.

Subphrenic Abscesses.

At the Gesellschaft der Aerzte, Ranzi exhibited a few cases, with a report on ten more whom he had operated on between April, 1901, and July, 1904. The primary origin of these cases, as far as could be obtained, was: Three from diseased appendix, four were the result of gastric troubles, one was due to an ulcer in the duodenum ; another was from a tubercular ulcer of the ascending colon, and the last from some cause unknown. With only two exceptions, all of the abscesses occurred on the right side in the intra-peritoneal folds. In nine of the cases the matter formed between the liver and the diaphragm, and in only one case was it found between the spleen, colon, and diaphragm. With respect to the formation of gas, this seems to be according to the rule given in textbooks, as five of the cases accorded to Leyden's description of the disease, pyo-pneumothorax subphrenicus, while others describe the disease as pyothorax subphrenicus, or empyema-hypophrenicus.

The diagnosis was a more difficult matter, although we must recommend it as secondary from some other inflammatory centre, such as typhlitis appendicitis, pleuritis, &c., but the most common origin given in books is gastric, which was not the rule in the ten cases just presented. The lowering of the liver and raising of the lungs with fever, and difficulty of respiration would justify the use of the exploring needle as a confirmatory test. Leyden recommended the use of the manometer to test the abdominal pressure for inspiration and expiration, which was greater in the former and less in the latter than the normal. If the chest were tested in the same manner the results would be opposite. The whole history must largely guide the careful clinician. The treatment recognised is generally operative, and although the prognosis given in books is bad, and fixed at 35 per cent., the ten cases recorded had only two deaths, or 28 per cent.

There are two methods of operating which may affect results—*viz.*, "Gruneisen's perpleural," or the abdominal. The former is not free from infectious complications, and was rigidly avoided in all these cases with the exception of one where secondary infection had already occurred.

Hochenegg and Schnitzler gave their experience, and concurred with Ranzi that the "perpleural" operation should be rigidly avoided.

CRETINISM.

Knoepfelmacher presented three sisters, the eldest, æt. 15, to show that the disease is hereditary as well as sporadic. The eldest is 100 centimetres long, or 30·37 inches, has myxœdema over the face and supraclavicular spaces; a dry, scurfy fold skin over the backs of the hands and instep of the feet. The four-year child had ossification in many bones, as shown by the Röntgen rays; speaking short expressions with a drawling monotone and rather coarse voice; apathetic, indolent and mentally defective.

The six-year-old brother is 81 centimetres, or 31·88 inches; upper and lower limbs equally long; the thyroid palpable; no decided myxœdema, but disturbed ossification according to Röntgen rays.

The youngest of the family, æt. 1½, fontanelle open; hand, short and plump; the skin dry and scurfy, while the child speaks in syllables and in monotone; it appears indolent, imbecile, and falls down with a plump.

The third, æt. 2½, 68 centimetres long, or 26·77 inches; fontanelle wide open; cannot walk, speaks little, and lies with the mouth open, and the tongue between the four teeth he has, while the skin is dry and scurfy. The parents of the children are Viennese, having been born and brought up in the city which they had left only a few days on a holiday. Their fathers before them were also brought up in the town, and no trace of consanguinity can be observed. The other children of the family are healthy, and no sign of thyroid or any other disturbance can be perceived. We must therefore conclude that these three cases are sporadic infantile myxœdema.

It is worthy of note that there is present a family hypothyroidism, although there is a tendency to goitre formation, which is not common in sporadic cretinism, as well as a want of distinct myxœdema in two of the cases.

Eiselsberg asked what his line of treatment was in all these cases?

Knoepfelmacher replied by saying his first form of treatment was the usual products of the thyroid gland substance given internally, but later on he resorted to Christiani's implantation of small pieces of the gland in the body of the patient.

Operating Theatres.

GREAT NORTHERN HOSPITAL.

Operation for Suppurative Appendicitis.—Mr. **Peyton Beale** operated on a youth, æt. about 14, who had been admitted with the following symptoms: Temperature 99, pulse about 130, suffering from diarrhœa, tongue very furred, pupils dilated, sweating freely, the sweat, together with the breath, having a distinctly fæcal odour; abdomen of normal aspect, resonant over the front and dull in each flank; no difficulty of micturition, nothing abnormal on rectal examination. The patient complained of pain all over the abdomen, but on careful investigation it was quite clear that this pain was neither in the skin nor in the abdomen, and on further examination it proved to be in the muscles, not only in those of the abdomen, but in all the voluntary muscles, so that pain was elicited when any of the muscles were tapped, and with the pain there was marked sudden contraction. The skin was really anæsthetic. As regards the previous history of the patient, eight days before admission, on returning home from a bicycle ride, he was seized with abdominal pain, referred chiefly to the umbilicus; he also had some diarrhœa, which continued for two or three days together with some vomiting, the vomit being stained with bile. The medical man who saw him supposed him to be suffering from ptomaine poisoning. By the fourth day after the onset of the symptoms the boy appeared to be practically well and free from pain, but the symptoms which were found on his admission to the hospita came on suddenly in the early morning of the day on which he was admitted. Mr. Beale considered that the case was one of ulceration of the appendix with perforation and general peritonitis of probably six or seven days' duration, and he operated at once by cutting down in the right iliac fossa. On opening the peritoneal cavity a large quantity of exceedingly foul pus escaped; a large concretion was lying loose and was picked out. The appendix was founds, its distal, two inches, being quite normal, but the intervening portion between it and the cæcum had ulcerated away completely, leaving a ragged rent in the cæcum from which fæcal matter was escaping The mesenterus holding the distal part of the appendix was ligatured, and the latter removed. The cæcum was pulled out of the wound, a number of adhesions being broken down to bring this about, the hand was then introduced into the peritoneal cavity, together with the end of a rubber tube attached to a steriliser containing hot sterile salt solution. The whole of the peritoneal cavity was next washed out rapidly, large quantities of pus being dislodged from the pelvis and from beneath the liver. The wound was then packed with large plugs of gauze so inserted as to prevent the cæcum from slipping back, and the wound was dressed in the ordinary way.

Mr. Beale remarked that this was a typical case of a variety of suppurative appendicitis which was, happily, very uncommon. In dealing with over 250 cases of localised or diffuse suppuration due to a lesion of the appendix he had only come across four or five of this variety. The peculiarity of the symptoms was due to a very extensive absorption of the poisonous toxin or toxins produced by the Bacillus coli into the blood stream, and this it was which produced the anæsthesia of the skin, the hyperæsthesia, and irritability of all the voluntary muscles—in some respects resembling strychnine poisoning—the dilatation of the pupils, and the noxious odour of the breath and sweat. In none of the four or five cases of this kind that he had seen and immediately operated upon were there any of the typical signs of suppurative appendicitis—they were masked entirely by the toxæmia—but in every one there was a history of a typical attack of appendicitis about seven to nine days previously, and which had, apparently, passed off, leaving the patient so well that in some cases he was able to resume his work, only to be seized a few days later by the symptoms such as are described as being present in the case he had just operated upon. In order to emphasize the class of symptoms, he mentioned the following as the first of this type of case which he had seen: Some years ago he was called to see a young man, æt. 21, living about six miles out of London, whose immediate symptoms were slight pain over the bladder, some impairment of memory and inability to fix the attention, muscular pains all over the body with spasmodic muscular twitchings constantly recurring, breath and sweat both had a noxious fæcal odour; the patient was constantly getting up and walking about the room, and was feeling on the whole fairly well. He had walked to his home from the City (six miles) that very day, but was seized with an attack of syncope soon after his arrival; his pupils were dilated and he was sweating freely. His previous history was interesting, for just a week before he suffered from a typical attack of appendicitis which kept him in bed for three days only, and from which his doctor believed he had completely recovered. Mr. Beale did not at that time realise the gravity of the man's symptoms, and gave a good prognosis after administering an enema with a very good loose action. This patient went to sleep at 12 o'clock the same night, woke up suddenly at 3 o'clock in the morning, ran round the room in a state of delirium, and dropped down dead on the floor. At a *post-mortem* examination next day, at which Mr. Beale was present, the abdomen was found full of pus, and the appendix ruptured and practically ulcerated away; the appearances rendering it quite certain that the rupture had occurred many days previously. Mr. Beale also referred to another case, which was perhaps still more striking. This was a lady, æt. 60, who was living on the coast of Devonshire and who had been treated one week previously for a typical attack of appendicitis which had subsided. The patient did not, however, feel perfectly well; she was of a very energetic temperament, and on the morning of the day on which Mr. Beale saw her she had actually walked three or four miles and bathed in the sea. She reached home with some difficulty on account of shortness of breath and irregularity of the heart's action, both of which she ascribed to a little indigestion. When Mr. Beale saw her about three hours after she had walked home she had a temperature of 100°, dilated pupils, very feeble rapid pulse, was sweating profusely, and slightly distended abdomen, absolute dulness in both flanks with emphysema beneath the skin all over the cæeum and ascending colon. An incision was immediately made in this region, and the abdomen was found full of pus with very large collections in the pelvis and beneath the hepatic flexure of the colon. Two concretions from a ruptured appendix were found free in the pelvis, and it was quite evident from the ulcerated stump, which was the only portion of the appendix left, that the rupture had occurred many days previously. This patient, therefore, had been walking about freely for several days with a ruptured appendix and her abdomen full of foul pus, and yet, although she was seen daily by a thoroughly capable medical man, he could discover no symptoms which could be regarded as serious. At the same time he admitted that he felt uneasy about the patient, but could not induce her to remain quiet in bed. From Mr. Beale's experience from these four or five cases, he considered that the only safe plan was to keep a patient who had suffered from an attack of appendicitis perfectly quiet for at least a week, after all acute symptoms had subsided, and that the patient's friends should be warned that danger from the attack had not passed away, and that an operation might still be necessary at a moment's notice. In his opinion, if there was the very slightest doubt, there was far less risk in opening the abdomen over or behind the cæcum and exploring than in leaving the patient alone.

The case operated on at the Great Northern Hospital reported above is still doing fairly well eight days after operation, but this was the only one of this type which he, Mr. Beale, had known to progress favourably after operation.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 19, 1905.

DR. DOYEN DISCOUNTENANCED BY THE PARIS COMMISSION.

EVENTS travel apace. A week ago we noticed in our leading columns the remarkable Report of the Cancer Research Association. In that notice a comparison was made between the patient logical methods of scientific investigation therein recorded and those of a French surgeon, who had established a kind of branch practice in London for the treatment of cancer on theoretical lines. The commercial side of that extraordinary new departure in international medical amenities was most unpleasantly apparent in the fact that the pamphlets of the surgeon in question were translated into many languages. Furthermore, in a recent notorious trial in France, it was shown that enormous fees had been charged to an American patient for treatment by a special serum prepared in accordance with uncorroborated theory and experiment. Dr. Doyen, before invading London, might at least have waited for the result of the scientific committee of inquiry appointed by the French Academy of Medicine. The report of that committee has now been issued, and if we are to believe the advance reports that have reached our shores, the whole fabric of Dr. Doyen's creation has been shattered, and shown to be worthless from one end to the other. This exposure will bring small comfort to the over-credulous persons who have been led by his unsubstantiated statements to pay large sums for treatment. It will, of course, be at once obvious to all who are acquainted with formal scientific methods that Dr. Doyen has acted in good faith, and that his erroneous conclusions were the result of faulty observation rather than of deliberate and cynical irresponsibility. Indeed, were it not for the too-assertive commercial aspect of the matter our sympathies would be cordially extended to Dr. Doyen as an enthusiast whose energies had induced him to overshoot the mark. As things stand, however, it is hardly possible to absolve the Paris surgeon from responsibility. Before he announced to the world the discovery of the specific pathogenic organism of cancer in the shape of the so-called micrococcus neoformans he should have taken every possible precaution to have had his observations controlled by independent workers. Had he done so, he would have been spared the mortification of subsequent exposure by the Paris Academy. We cannot conceive a more unhappy position than that of a medical man who has received large sums of money on the strength of alleged discoveries that would not survive an ordinary scientific investigaton. The whole affair, indeed, presents a painful picture of the man of science who is led into untenable positions because of the faultiness of his intellectual methods. That the cause of cancer and its consequent cure will one day be discovered can hardly be doubted in the light of the faith created by the marvels of modern science. It is to be hoped, however, that when the good news comes it will bring good to all humanity rather than fabulous wealth to the coffers of any single human being. It will be a sad day for the honour and dignity of medical science when it adopts the methods of the modern man of business, who must become rich at all costs. The history of Dr. Doyen's campaign is soon told. He isolated an organism, the micrococcus neoformans, which he pronounced to be the specific pathogenetic organism of carcinoma. With the aid of cultures of this microbe he produced a serum with which he claimed to be able to cure cancerous disease in human beings. The French Academy of Medicine ultimately appointed a Commission of five eminent members to test his claims. Twenty-four patients were produced by Dr. Doyen, and treated by him under the scrutiny of the Commissioners. Of these patients several died, the greater number grew worse, some remained stationary, but no single instance of cure is reported. More than that, the report states that not one of the twenty-four patients experimented upon in all these months has derived the slightest good from the new treatment. The following sentence from Dr. Delbet may be quoted: "Nothing whatever has been observed in the examination conducted by Commission to justify us in saying that Dr. Doyen's treatment is in any way beneficial to patients suffering from cancer." And thus is pricked another bubble reputation.

VACCINATION POLICY.

There are some tenets of the faith medical which it is as dangerous to impugn or to criticise as any of the faith theological. This is more easily comprehensible than justifiable. It is comprehensible that after warm discussion and recriminations have raged round a question, opponents are apt to resent interference with any *modus vivendi* that may have been patched up between them; but when the opponents on one side are medical men, it is only to be expected that their superior intellectual training will give them grace to listen carefully to any new light on the subject, even if need be to the extent of suffering fools gladly. The question of vaccination has been, and still at intervals continues to be, a subject of much feeling. It is only natural that when a preventive measure of practically absolute efficacy has been discovered and freely given to humanity medical men should feel not only hurt at the ingratitude of those who reject it with scorn, but impatient with the pettifogging sophisms and pinchbeck arguments with which its rejectors support their opposition. To any man who has had experience of small-pox, and, indeed, to any man whose mind is open to reason, the protection afforded by recent vaccination is the most self-evident phenomenon in a world of chimeras. Only the hopelessly ignorant or the hopelessly prejudiced would venture to doubt it; no amount of fresh evidence could upset the experience of the past that so far as efficient, recently performed vaccination as a prevention of small-pox is concerned, the question is no longer a question; it is a *chose jugée*. The anti-vaccinationists never tire of taunting present-day advocates of vaccination with the mistake made by the early vaccinationists in thinking that the protection afforded by vaccination was life-long. Rhetorically, such reproaches enjoy a certain success; but they do nothing to further the elucidation of truth. All observers of small-pox are aware that although the protective influence of vaccination is all but absolute for several years after a successful operation, the protection gradually lessens as time passes, until it is barely, if at all, traceable in old age. Consequently the Acts that have made the vaccination of infants compulsory, have had the effect of altering the age-incidence of small-pox in the community, so that the disease when it appears in well-vaccinated communities, now affects persons in adolescence and middle-age rather than the young. The Acts have had this effect, but they have not eliminated small-pox from the country, nor is it scientific to expect that they will. Besides the unvaccinated, there remains a large susceptible vaccinated population, and this factor can be eliminated only by stringent re-vaccination, and if we may use the expression, re-re-vaccination. Now in discussing a matter of this kind, it is necessary wholly to dissociate the medical question of the efficacy of vaccination—which no reasonable man disputes—from the political question of how the community is to be secured from the dangers of small-pox—which many unreasonable people dispute bitterly. The medical profession have done their duty faithfully in urging that the only complete safety lies in universal vaccination and re-vaccination, and the country as a whole have rejected the policy. With regard to primary vaccination, a serious loophole is created by the refusal of many people to have their children vaccinated, and recently the Government have announced that they propose to take no steps with regard to re-vaccination. It may be taken for granted that the Liberal party, if they come to power at the next election, are even less likely to make any move of the kind. The point, therefore, remains—how far partial primary vaccination is protective to the whole community? It has been pointed out more than once, and the fact receives illustration in every outbreak of small-pox, that a good deal of the dissemination of the disease is carried on by mild cases of the disease occurring in vaccinated persons, who are not sufficiently ill to seek advice. In this way the good done by primary vaccination in protecting children is to a certain extent counteracted by the harm done by the vaccinated adults, and the assessment of this factor is a point of grave importance. Moreover, there remains the reflection that a great deal of the stupid, unreasoning prejudice against vaccination is due to the compulsory character of the vaccination laws, for despite the conscience clause, vaccination is still more or less compulsory, and the effect of the old severe and the new benign compulsion are still powerful elements in stiffening the necks of the anti-vaccinationists. Those who are watching the newer phases of the vaccination question will be interested to read the report on the small-pox epidemic of 1904 at Leicester recently presented by Dr. Killick Millard, the medical officer of health for that borough. Leicester is a notoriously badly vaccinated town, and its small-pox future has been mapped out for it in gloomy terms; but though it has passed through outbreaks in 1903 and 1904, the methods adopted by the sanitary department have been remarkably successful. In the former year 394 cases occurred with 21 deaths, and in the latter 321 cases with but four deaths. A vigorous policy of isolation, disinfection, and vaccination of contacts has been pursued, and whether by good-luck or good management, the results have proved surprisingly at variance with the predictions of the past. In making itself the *corpus vile* on which a gigantic experiment in public health may be performed, Leicester is obligingly doing for itself what no one would have suggested should be done to it, but there is no denying that if with an efficient staff and a complete modern organisation it is able to cope with all future outbreaks as successfully as with those of 1903 and 1904, it will take out of the criticisms that have been levelled at it much of their sting. But many years must yet elapse before the experiment can be held to be complete.

THE TEACHING OF OPERATIVE SURGERY.

THE traditional method of teaching operative surgery by the actual performance by the student of operations on the dead body has much to recommend it. It has the great advantage of forming a connecting link between the dissecting-room and the hospital theatre, while it impresses on the student the fact that all surgical procedure is based on anatomic knowledge. It allows him to recognise structures in a similar condition to that in which he is used to them in the dissecting-room, although he approaches them from a different stand-point. As long, too, as surgical operations were performed only along the lines of certain "classical operations," a student could gain knowledge of the special method required for each operation by work on the *cadaver* better than by any other means. In pre-anæsthetic days, when speed was of the utmost importance, a precise knowledge of the steps of a proposed operation was a matter of greater moment than at present. Nowadays, however, a somewhat different kind of knowledge and skill is required in a surgeon, and it must be admitted that a course of operative surgery on the *cadaver* alone is not sufficient in giving the necessary knowledge of operative procedures. The most important part of surgical technique at the present day is not the use of the hands or of the tools, but the thorough practice of asepsis. So far from helping to a knowledge of aseptic methods operative work on the dead body carries with it necessarily an entire disregard of surgical cleanliness. The success of a surgeon nowadays depends, not on his performing a "neat" operation, but on his knowing how to prevent sepsis developing in his wounds. Moreover, with the freedom given by aseptic methods and the use of anæsthetics, but little regard is paid to the classical methods. An operator does not proceed by cast-iron plan, but he gives himself leave to change his road to the desired end should he think it advisable so to do in the course of operation. Every man is, in fact, a law unto himself. Under these circumstances it is obvious that the traditional method of instruction has not the same value at the present day as it possessed a generation or two ago. It emphasises points which are gradually losing their importance, while it entirely fails to supply certain requirements of modern surgery. With the view of remedying these defects, and of accustoming students to the manipulation of living tissues, some of the American schools, notably that of Johns Hopkins, have adopted the method of supplementing instruction on the *cadaver* by a course of what is termed "comparative surgery." This is, in fact, a course of operative surgery on the lower animals, the treatment of each patient being as closely as possible assimilated to the surgical treatment of human beings in hospital. Clinical histories are kept on regular hospital sheets; the effect of the anæsthesia on pulse and temperature are noted; pathological notes and post-operative facts are recorded; and where death occurs, a careful autopsy is performed. Measures are taken to protect against sepsis just as strictly as in the case of human patients, and notes are kept of the steps adopted to procure cleanliness both of operator and of patient. By operating under such circumstances a responsibility is added which is entirely absent if operations be only on the *cadaver*. The student, in dealing with a living patient, has to look forward to the progress of the case as his justification or condemnation, just as in the case of a human being. Moreover, on a living subject—and on a living subject only—can he learn, let us say, how to deal with hæmorrhage, or how to protect an abdominal cavity from infection. There are, however, obvious difficulties in adopting the method in these countries. The difficulty of obtaining sufficient material, and the obstacles imposed by the laws regulating vivisection, place a formidable though not an insuperable bar in the way. In America, similar difficulties were at first met, but as time went on, at Johns Hopkins Hospital, at least, a most pleasing solution was found. Learning of the work, the owners of animals suffering from surgical diseases, which in many cases veterinary surgeons are loth to operate on, have begun to bring them to the surgical teachers for operation, with the result that there is now promise of an animal clinique which may furnish material sufficient for teaching operations. That thoroughly sound work is done from the points of view of both student and patient, is shown by the careful records of cases published in the official journal of that institution.

Notes on Current Topics.

Taxation of Scientific Instruments.

As to whether Protection or Free Trade be the better State policy, we are not prepared to offer an opinion, but to men of science, at any rate, there are certain advantages in living in a country of free imports. For instance, we in this country have great advantage over our American colleagues in that scientific instruments are not subject to a heavy tariff. There is, for instance, in the United States a heavy import duty on microscopes, with the result that purchasers must either pay a very high price for an inferior instrument to an American maker, or pay an enormous tax on a European article. Nowadays, when microscopes are a necessity for every intelligent physician, a law like this acts as a serious bar to the progress of the scientific knowledge of medicine. A peculiarly hard case of the application of this law has lately been made known by Professor Councilman in a correspondence published in the American journals. A medical man, a pupil of Dr. Councilman's, 1902 had bought a Zeiss microscope, paying full duty thereon on its arrival in America. In 1904, he brought the instrument with him to Manila, and while there, one of the lenses requiring repair, he despatched it to Jena. It has now been returned to America, but is held in Boston Custom-house for a duty of fourteen and a half dollars. As the original cost of the lens was about thirty-five dollars, it is now perhaps worth some twenty-five, and Dr. Councilman, drawing attention to the hardship of the case, has appealed to the United States Treasury for remission of the duty. The Treasury officials, however, decline to afford any relief, quoting the law that "dutiable merchandise imported, and afterwards exported, although it may have paid duty on the first importation, is liable to duty on every subsequent importation."

Ambulances for London.

We are glad to see that the long promised Ambulance Scheme of the London County Council has at last been produced. The Council propose to begin in a small way, and the scheme generally suggests an amount of self-diffidence that is rather surprising. Londoners are in earnest about having some ready and useful form of aid for street accidents, and they have waited for it far too long already. The County Council propose to erect one principal and seven district stations, to which access may be obtained by street calls similar to those used for the fire-brigade. At each station there will be a motor ambulance, and two or three men trained in first aid. One of the men is to be married, and the wife is to keep house for them all. At the principal station there is to be a superintendent of the whole service, five ambulance drivers, and servants. After the scheme has been approved by the Council, parliamentary powers will have to be sought, and we hope there will be wide enough scope to admit of an extension of the very modest proposals now put forward. Eight stations for the whole of London cannot be regarded as excessive, for it must be remembered that the utility of such a service depends on the needful assistance being obtainable at a few minutes' notice. If injured people have to lie in the streets while the ambulance is summoned from a distance of some miles, it is not improbable that serious complaints will be made. It is to be hoped that power will be sought to inflict severe fines on people who summon the ambulances needlessly, or for slight causes, as they might easily be kept racing about all day to attend to the cuts and bruises that are daily sustained by wayfarers. We notice that, as might have been expected, there is to be no recourse to medical advice; first aid proficiency being deemed all that is essential to equip an uneducated man to deal with the gravest emergencies in the streets of a vast city.

A Dust-arresting Respirator.

The discovery of a trustworthy dust-arresting respirator for the use of those engaged in dusty trades would be of considerable importance to public health. That we are not within easy distance of such discovery would seem to be shown by the failure of the Society of Arts to receive any satisfactory response to their offer of a prize for such an apparatus. It will be remembered that a couple of years ago the Society offered a prize for the best dust-arresting respirator, and the decision of the committee of adjudicators has recently been published. (*a*) It appears that no less than sixty applications for the prize were received, of which thirty-three, or more than half, came from abroad. Out of the entire number the committee have failed to find any which they could recommend for a prize. This is not perhaps matter for wonder, as we hardly think the genius of an inventor is likely to be much stimulated by the offer of a prize, and if there had already been any trustworthy apparatus it would have been known. Among so many appliances offered, there was, of course, great variety of device, but most of those of any promise, in the eyes of the committee, were respirators of the bag type, furnished with a pad of some sort to arrest dust. In nearly all, however, the air passages were insufficient, and the use of the instrument would be exhausting to the wearer. While the enterprise of the Society of Arts has hardly done much to prevent the inhalation of dust, it has, in another sense, cleared the air, as it has shown that while there are many useful respirators in actual employment, there is none which can be regarded as entirely trustworthy and convenient.

Louis XI.'s Physician.

THE monarch of old had a sharp and effective way of dealing with those of his courtiers and servants from whom he disagreed, and the physician who wished to retain his post as attendant to the Court had to tread warily among the pitfalls that beset his path. It is not surprising therefore, that many a Court physician became something of a sycophant, and it is pleasing to read of one, at least, who retained his independence, even if the means he used were not those that would commend themselves to the practitioners of to-day. Louis XI. is notorious as having been one of the most fickle and untrustworthy kings in history, and especially towards the end of his life, was constantly dismissing his attendants and clapping his courtiers into prison or subjecting them to torture. The only officer whose influence over him never wavered was his physician, Dr. James Coctier, who not only demanded exorbitant fees for himself and good appointments for his friends, but treated the King with a *sang froid* which amounted almost to contempt. Comines records of him that in Louis' last illness he charged him 54,000 crowns in cash for his services, obtained the Bishopric of Amiens for his nephew, and other great offices and estates for himself and his friends. "Yet this doctor used him so scurvily, one would not have given such unbecoming language to one's servants, as he gave the King, who stood in such awe of him he durst not forbid him his presence." Coctier's influence seems to have rested in a threat to the King, that if his Majesty dismissed him as he had done many other officers, he (the King) would not live eight days. So terrified was Louis that he followed Coctier's injunctions to the letter, and to the chagrin of his followers, continued to flatter his physician, who fawned upon him: "which," adds the historian, "must needs be a great mortification to a Prince who had been obeyed all along by so many brave men much above the doctor's quality."

Dermic Malingering.

THE literature of malingering is by now fairly large, though for the most part scattered and not easily accessible. An interesting account of a rather rare mode of malingering—the production of skin eruptions—has recently been published by Dr. Heidingsfeld of Cincinnati (*a*). As with other forms of malingering the subjects most affected belong nearly altogether to one of two classes, men who wish to escape work or military service, and hysterical young women. All Dr. Heidingsfeld's patients belonged to the latter class, the assumption being that the motives actuating the former class are absent in happy Cincinnati. Feigned eruptions can for the most part, be recognised by their peculiar form, unlike any known lesion of disease, and by their localisation to parts easily accessible with the right hand. In many of the cases, although there was no doubt as to the diagnosis, it was found impossible to discover the means by which the lesions had been produced. In two, for instance, the left arm was marked by very regular excoriations a couple of inches long by half an inch broad, such as might be produced by rubbing with a piece of glass; warning the patient that the nature of the disease was known prevented the appearance of any further lesions. In another very peculiar case the lower limbs were found studded with superficial abscesses. Careful examination revealed that each abscess contained a pin or needle, and in all, some hundred pins or needles were removed from the patient. The motive in this case was self-torture on religious grounds. The importance of being able to recognise self-inflicted lesions of the skin is very great, as in some of Dr. Heidingsfeld's cases, heroic measures had been advised by other physicians before the true nature of the case had been recognised.

Another "Bloodless Surgeon."

THE Medical Defence Union have added another to their long series of successful prosecutions against offenders under the Medical Acts. The defendant was in individual named Walford Bodie, of Arundel Street, Leicester Square, who masqueraded at the Camberwell Palace of Varieies' and other music halls as "the Bloodless Surgeon." In this capacity he did "turns" which consisted in treating by mesmerism, hypnotism, and magnetism, people "given up" by other surgeons. We are not sure that even a metropolitan magistrate might not hold the description "Bloodless

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(*a*) *Journal of the Society of Arts*, June 9th, 1905.

(*a*) *The Lancet*, April 29th, 1905.

Surgeon" to be an offence against the Acts—certainly the use of the word "surgeon" would be sufficient to do so under an ordinary reading of the law—but "Dr." Bodie made the assurance of his conviction doubly sure by having the letters "M.D." appended to his name. Mr. Avory, who defended, put forward the excuse that the initials "U. S. A." should have been added to those of "M.D.," as Bodie possessed medical degrees in America that entitled him to use the letters "M.D." and "C. M." It should be well-known that there is no University in America that can be described by initials as "U. S. A." any more than there is any English University that can be described as "Eng." Any diploma purporting to allow a man to practise medicine under the description "M.D., U.S.A." would be as worthless for State purposes in America as it would in this country. The magistrate, Mr. Francis, agreed with Mr. Avory that the case was not one that called for a heavy penalty, and inflicted a fine of £5 with £5 5s. costs. We wonder if Mr. Francis would consider it a bad case if some adventurous spirit were to describe himself as a "Barrister-at-Law," and appear on the stage of second-class music halls to give displays of his forensic cunning.

Singular Death from a Blow.

A case of much medico-legal interest was investigated last week by Major Arundel, coroner for Pontefract. The inquiry was held upon the body of Arthur Wilson, aged 16, a stonemason's apprentice. The evidence of the boy's friends showed that on the evening of his death, deceased and others met a boy of twelve named Herbert Gardham, who had been fishing and had a rod in his hand. Wilson and Gardham began to quarrel, and after Wilson had struck Gardham several times with his fist, Gardham retaliated and struck Wilson across the region of the stomach with the fishing rod. Wilson stood for a second with his hand upon his stomach, then dropped to the ground, and died after gasping once or twice. Dr. Rigby, who was called immediately, said that he tried artificial respiration for an hour, but without avail. He had made a post-mortem examination of the body, and found all the organs healthy and quite normal. There were no external marks beyond a bruise upon the right shin about the size of a sixpence. None of the abdominal organs were in the least diseased. Witness was of opinion that death was due to syncope consequent upon the blow. He did not think it was due to excitement. A heavy blow such as might have been given from the fishing rod produced would probably cause a reflex action from the nerves of the stomach to the nerves of the heart, which would cease beating at once and death would be instantaneous. This would especially be the case if the blow were unexpected and the stomach full of food, as was the case. In reply to a question he thought the deceased could not have been expecting the blow where he got it, or the abdominal walls would have become rigid and probably there would have been no evil result. The jury, after retiring, returned a verdict that death was due to syncope consequent upon the blow given by Gardham who, by misadventure and against his will, had caused the death of Wilson.

Damages for Enteric Fever.

The establishment of the responsibility of property owners for disease arising out of negligence of sanitary matters is clearly of great importance to the community. From this point of view the attention of our readers may be called to a recent case settled in the Derby County Court. The plaintiffs brought an action to recover £70 damages for illness alleged to have been caused by certain sanitary defects in a house of which they were tenants and the defendant was owner. The property in question was one of a block of four cottages, in which drains were conspicuous by their entire absence, and which had been visited by typhoid fever no fewer than four times, with one death. In February, 1904, the premises were condemned by the Medical Officer of Health as unfit for human habitation. Nothing was done by the defendant and the plaintiffs later contracted typhoid fever. The case was tried by a jury, who were called upon to decide a number of questions of fact. The reassuring feature so far as the future of public health administration is concerned lies in the verdict of £24 10s., with costs entered in favour of the plaintiffs. The offence in this instance was aggravated by the fact that the owner of the cottages was Chairman of the Chelmorton Parish Council, a member of the Bakewell Rural District Council, and a member of the Sanitary Committee of that body. No wonder the county medical officer of health is so often hampered in the discharge of his duties.

Dr. Doyen's Serum.

The general bearing of the exposure of the worthlessness of Dr. Doyen's so-called "discoveries" is noted at length in our leading columns. We cannot assume any expression of surprise at the news that the Committee appointed after the Surgical Congress in Paris last January to investigate Dr. Doyen's cancer serum has pronounced it to be a failure. Dr. Doyen's methods are sufficiently well-known to the readers of this journal to need no further comment. Dr. Delbet, who read the report to the Surgical Society, informed his audience that the Committee were unable to satisfy themselves of even the existence of the "micrococcus neoformans," which was supposed to be the bacterium of cancer, and by means of which the serum was prepared. The therapeutic investigation had lasted five months, and twenty-six patients had been under observation! Nothing was noticed in these cases except the "temporary deceptive improvement which usually follows the first use of serums in general." The conclusions formed after watching the twenty-six cases were that twenty were unmistakably worse, two remained in an unaltered condition, and in one recrudescence had occurred. The other three cases had not been sufficiently long under observation for a definite pronouncement to be made. It would seem, then, that Dr. Doyen's serum is destined in the near future to take its place in the limbo of discarded "cures" for cancer—that is if there be any room left for its reception. It remains to be seen if Dr. Doyen will pursue the plan of establishing a home for cancer patients in London, as we have been given to understand he purposes to do.

A Jenner Centenary.

JULY 4th of the present year marked a somewhat interesting centenary in connection with the illustrious discoverer of vaccination. On that date 100 years ago he was presented with the Honorary Freedom of the City of London. At a meeting of the Court of Common Council on August 11th, 1803, it was resolved that the Freedom of the City should be presented to Dr. Jenner in a gold box, "as a token of their sense of his skill and perseverance in bringing into general use the inoculation of the cow pock." In his reply on the occasion of the presentation Dr. Jenner expressed a hope that the act of the Corporation would counteract those attempts which had been recently made to retard the progress of vaccination: attempts which he boldly declared originated entirely either from ignorance or from prejudice. A hundred years later and the worthy doctor might be using the same words in an address to the Corporation. But his discovery has nevertheless worked a revolution during the intervening century.

A Modern Niobe.

THE readiness with which the average woman gives way to tears on the small provocation provided by the refusal of a new hat or the suggestion that the time is ripe for administering corporal punishment to her erring infant, is only equalled by the promptitude with which the tears cease when the occasion for them has passed. We read in *American Medicine* for July 1st, of a lady of Sioux City whose case forms an exception to this happy rule. The proximate cause of the trouble is not stated, but it appears that for some reason or another Mrs. Kate Wilbourn found cause for weeping; and once opened the floodgates refused to close. We can imagine the consternation of Mrs. Wilbourn and her friends when they found their efforts at consolation were in vain, but at the time of writing the poor lady had been crying incessantly and uncontrollably for four days, and no advice or treatment had any effect. The patient does not seem to have been particularly unhappy, and she is asserted to be perfectly sane, but of her own accord she presented herself to the Board of Insanity Commissioners and asked to be committed to a State Asylum, for she felt sure the hospital physicians could relieve her. We recently came across the case of a patient who was so much amused at a joke he heard at a theatre that he laughed and chuckled at it for two years, to the disruption of his domestic happiness and the disorganisation of his professional work. We hope that the subsequent career of Mrs. Wilbourn will be related, for one can only hope her future may not be so dismal as that of the poor creature whom Latona treated so shabbily.

PERSONAL.

HIS MAJESTY THE KING has ordered that three wards in the Military Hospital, Millbank, shall be named respectively "King Edward," "Queen Alexandra," and "Princess Victoria," in commemoration of their Majesties' inspection of the hospital on the 1st inst.

THE first session of the Congrés International des Gouttes de Lait will be held in Paris on October 20th and 21st. The presidents are Dr. Variot, physician to the Children's Hospital, and Dr. Dufour, the founder of the "*goutte de lait.*"

KATHARINE COUNTESS OF STAMFORD AND WARRINGTON, whose will has now been proved, left £200 each to the Queen's and General Hospitals, Birmingham; £500 to the Leicester Infirmary in aid of the Children's Hospital; and £100 to Corbett's Hospital, Stourbridge.

A NEW Dental Hospital was formally opened at Birmingham on July 6th by Sir Oliver Lodge, Principal of the University.

AT a meeting of the Manchester and District Association of the Fellows of the Royal College of Surgeons of England, held on July 8th, the following propositions were passed: That it is desirable that Manchester be represented on the Council of the Royal College of Surgeons. That Mr. G. A. Wright be requested to stand as a candidate for the next election.

AT a quarterly meeting of the Council of the Royal College of Surgeons of England last week Mr. Tweedy was re-elected president and Mr. Henry T. Butlin and Mr. Edmund Owen were elected vice-presidents for the ensuing year.

AT the same meeting of the College the following professors and lecturers were elected:—Hunterian Professors: Warrington Haward, A. H. Cheatle, H. J. Paterson, and C. G. Seligmann. Arris and Gale Lecturers: J. H. Watson and Sydney W. Curl. Erasmus Wilson Lecturer: James Sherren.

ON reference to the report from our Edinburgh correspondent in another column, it will be seen that Sir Wm. Muir, the venerable Principal of Edinburgh University, who recently resigned that position on account of failing health, passed away last week, in the eighty-sixth year of his age.

DR. DAVID WALSH will read a paper on the "Cap Film Isolation of Ringworm" at the Public Health Congress held this week at King's College, London.

THE Long Fox Memorial Lecture for this year will be delivered by Dr. E. Markham Skerritt in November.

A REPRESENTATIVE Committee of those interested in the Amalgamation of Medical Societies has been formed of delegates from thirty-seven medical societies.

DR. SINCLAIR of Dundee, is the new President of the Forfarshire Medical Association.

PROF. R. SAUNDBY has been appointed on the recommendation of the Senate, as a delegate to represent the Medical Faculty of the Birmingham University at the International Congress of Medicine to be held in Lisbon in 1906.

Dr. Frederick W. Price has been appointed Medical Registrar of Westminster Hospital.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

SCOTLAND.

DEATH OF SIR WILLIAM MUIR.

The venerable Sir William Muir, lately Principal of the University of Edinburgh, passed away, in the eighty-sixth year of his age, on July 11th. He had resigned his Principalship on account of failing health, in 1902, after having served his alma mater for nearly a score of years, but was able to lead his usual life until about ten days ago, when his strength gave way, and though hopes were at first entertained that the indisposition might be merely temporary, he never rallied from it. Sir William Muir was an Ayrshire man, of a respected burgess family. With his three brothers, he was educated for the East India Company's service, and was a matriculated student of the University over which in later years he was to preside in the years 1833 and 1834. More than half a century elapsed, however, before he returned to Edinburgh as Principal—years of strenuous work in India, marked by the high administrative capacity and unswerving devotion to duty which more than justified the honours with which his country repaid him. During the Mutiny he was shut up in Agra, where he acted as head of the Intelligence Department, and was the friend and fellow-worker of the chief actors in that historic struggle; when peace was restored he became Secretary to the Viceroy, and superintended the re-organisation of the North-West Provinces. Thereafter he was member of the Legislative Council, and then Lieutenant Governor of the North-Western Provinces—the ruler of forty millions of men. In 1874 he became Finance Member of Council, and two years later retired from the Indian Service, though from 1876 to 1885 he continued to place at the disposal of the Empire his intimate knowledge of Indian affairs by continuing as a member of the Indian Council in London. In 1867 he was made Knight Commander of the Star of India, and when the Principalship of the University became vacant through the death of Sir Alexander Grant in 1885, the Curators selected Muir as his successor. His eighteen years of office were conspicuous for the hospitality and graciousness with which he presided at the head of the University; his relations with the students were especially friendly, and his influence on them—the intangible influence of an upright, gracious, and tactful personality—was none the less strong that it is difficult to express it in words. By none was the venerable Principal more beloved than by the undergraduates, and no interests were dearer to him than theirs. He took the deepest interest in all projects—social, intellectual, and athletic—which made for their welfare, and thoroughly earned the name of a "Students' Principal." During his term of office the University came under the influence of the Universities Act of 1889, and the operation of the Universities Commission; the McEwan Hall was built, and the University Union became a centre of social life among the students. Sir William Muir was an Oriental scholar of renown, and his writings on Mohammedan literature, on Mahomet, on the Caliphate, and allied topics earned for him the D.C.L.Oxon., the Ph.D. Bologna, and the LL.D. of Glasgow and Edinburgh.

The forty-second annual conference of the British Pharmaceutical Society will take place at Brighton from July 24th to 28th, under the presidency of Mr. W. H. Gibson, F.C.S.

The Committee of the Hospital for Sick Children, Great Ormond Street, has received a donation of 100 guineas from the Mercers' Company.

Correspondence.

THE REPORT OF THE IMPERIAL CANCER RESEARCH FUND.

To the Editor of The Medical Press and Circular.

Sir,—I was interested to read the excellent article which appeared in your last issue, with the general tenour of which I am quite in accord. Nevertheless, it seems to me that a few points in reference to the scientific work conducted by the Fund calls for some comment.

Sir William Church, in moving the adoption of the annual report of the General Committee, is stated to have said that "the malignancy of cancer appears to consist in the inherent power the cells possess of division and multiplication. If we can find out teh nature of this apparently unlimited growth it is not unreasonable to hope that we may be successful in obtaining means for checking or limiting their proliferation, and thus neutralising their malignancy."

I venture to submit that the conclusions regarding the nature of this unlimited growth and the probable means of checking or limiting the cell proliferation and neutralising the malignancy of the cells or their secretion have already been advanced in your columns and elsewhere.

Dr. J. Beard (1) has stated that it is not in the nature of parasitic maladies to lead to that unrestricted cellular increase and multiplication such as is characteristic of cancer. According to his investigations founded on embryological research, for some time he has taught, as for example, say, in the fowl, that the fertilised egg or the product of the union of sperm and egg does not *directly* give rise to the chick, but to a pre-embryonic "trophoblast" or larva; in man the chorion, which is capable of indefinite unrestricted cellular increase and multiplication. Upon this trophoblast arise the "primary germ cells," *one* of which forms the embryo. The rest migrate into the embryo, the majority reaching the germinal ridge from which the reproductive cells arise, and which thus are not formed by the embryo, but handed down to it in "morphological continuity," and for which it serves as a temporary shelter. It never happens, however, that all the germ cells find their way to the normal position in the embryo. Some may remain dormant, commencing later to grow. Cancer is this uncontrolled and imperfect attempt to repeat the life cycle of trophoblast and germ cells with all their enormous inherent potentialities of cell growth and other properties. Dr. Beard himself notes that Nusbaum in 1880 enunciated the conclusion that the germ cells must be special cells of the egg cleavage, which at no time took a share in forming the individual, but which were intended for future generations; that is to say, the segmented egg divides into somatic cells and the germ cells. This, or that of Boveri is the hypothesis apparently entertained in the Report of the Imperial Cancer Research Fund. On the other hand, Dr. Beard holds that when cleavage is really finished there are no somatic cells present, that the formation of germ cells is found to take place prior to the appearance of any trace of an embryo.

Amongst other confirmatory facts supporting Dr. Beard's conclusions by various observers may be noted the recent embryological conclusions of Dr. J. Voigt (Göttingen). He has found, as I understand, that human trophoblast possesses the structure of carcinoma even down to the "prickles" of squamous epithelioma, and he, like Dr. Beard, also comments on the fact that trophoblast of *early* gestation and carcinoma have the like physiological properties.

The one hopeful aspect of this embryological view, as taught by Dr. Beard, is that in normal development at a certain period the embryo is able to suppress the trophoblastic foundation upon which it arises; in the commencing functional activities of the pancreas which initiates an alkaline digestion and ferment—"with good reason for the hope if not the sure belief that the same means might also be potent when directed against and in the treatment of cancer."

On other grounds, as pointed out I(2) had myself independently arrived at the conclusion that in cancer the function of the pancreas was in part at fault, and had been led to commence trial of hypodermic injections of its proteolytic ferment trypsin, in the treatment of inoperable cancer.

Subsequently, and in the now admitted failure of "sera," Dr. Beard (3) drew attention to the important fact discovered by Prof. Blumenthal, Bergell and others (Berlin), that all carcinomata are always very easily digested by pancreatin.

So that the import of trypsin and its indication in the treatment of cancer alone, or aided by other substances which increase its action, has been arrived at independently by different observers and from different routes of enquiry.

Hitherto I may remark that no adequate explanation has been advanced of cases in which cancer has been known to disappear spontaneously. In view of the above considerations, it is not unreasonable to suggest that the function of the pancreas, temporarily interfered with or inhibited, has been restored. So also in the question of age incidence, the possible premature decay of the pancreas in advancing years may be suggested, or in cases of cancer in the young, its imperfect developmental function. Just as the amylolytic properties of saliva are know to vary in different animals so also possibly may the proteolytic properties of the pancreatic ferment—explanatory of varying susceptibility to transplanted growth, or that this secretion sufficient to deal with the natural need of the economy is not sufficient to control the transplanted growth, or neutralise the intracellular acid malignancy.

I am, Sir, yours truly,
JOHN A. SHAW-MACKENZIE, M.D.Lond.
London, July 13th, 1905.

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(1) "Embryological Aspects and Etiology of Carcinoma." By J. Beard, D.Sc., University Lecturer in Comparative Embryology, Edinburgh. The *Lancet*, June 21st, 1902. "A Morphological Continuity of Germ Cells as the Basis of Heredity and Variation," 1904. "The Cancer Problem." The *Lancet*, February 4th, 1905.

(2) The *Lancet*, January 14th and February 11th, 1905. THE MEDICAL PRESS AND CIRCULAR, March 8th, 1905. *British Medical Journal*, May 27th, 1905.

(3) "The Chemistry of Cancer." By Prof. F. Blumenthal, of the Cancer Research Institute, Berlin. Translated by J. Beard. THE MEDICAL PRESS AND CIRCULAR, April 12th, 1905.

ABOLITION OF VIVISECTION.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—That distinguished member of our profession, Dr. Hadwen, who devotes his talents so generously to the cause of anti-vivisection, seems to have quite won over the *Evening Standard*. Supporting Dr. Hadwen's views, the Editor in his issue of July 15th appears to insist upon what he styles "the guiding principle that dumb animals should not be made to suffer that the higher may gain a problematical benefit." One wonders whether the Editor has ever heard of the practice of castrating and splaying animals with the object of making them more docile, or rendering their flesh more suitable for food. Is he aware that these painful operations are performed without anæsthesia upon at least one half of all the horses, cattle, sheep, swine, and fowls, used in the service of man? Will he tell us whether the infliction of such an amount of pain with such an aim is justifiable on the grounds of expediency or morality; and if not whether he does not consider he might well begin with an endeavour to diminish this vast amount of suffering before attempting to put an end to experimentation on animals, which, even at the grotesquely exaggerated estimate of fanatics, cannot be considered as more than a single pin-prick in comparison.

I am, Sir, yours truly,
PHYSIOLOGIST.

"ALLUROPHOBIA," OR FEAR OF CATS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your interesting article on the above subject various symptoms are enumerated as having been produced by the presence of cats—sneezing, chilly sensations, suggestive of "catarrh." We are surprised there is no mention of "catalepsy," nor is any allusion made to female patients being more susceptible during the "catamenia"!

Of course, numerous other symptoms could be collected and form a category. Should the complaints produced by allurophobia become at any time epidemic, it would be nothing less than a "catastrophy," for the treatment of which a mere cataplasm would not be sufficient. In well-marked hysterical cases the threatened application of the cat (and nine tails) might prove effective. We only wish that "allurophobia" (or fear of the cat) could be extended to the East End hooligan.

I am, sir, yours truly,
London, W., July 14th. **ALEXANDER DUKE.**

THE GUILD OF HEALTH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your "Notices to Correspondents" you offer the following remark:—"Mr. C. H. S.—The insertion of your letter would open up a discussion on religious subjects, for which our columns are unsuitable, and which it has always been our rule to avoid."

Now, Sir, I submit that credential religion is as closely allied with insanity as is alcohol, and since the discussion of one in a medical journal is as necessary as that of the other, that is if we hope to penetrate into the causes and deplete our public asylums of so many sad cases of so-called religious mania.

In a clerical contemporary a work by Mr. A. Lewis Bettany, "The Confessions of Lord Byron," is reviewed, and among them is one where the poet regards insanity as having been mistaken for inspiration—an opinion beyond doubt that numbers share in.

I am, Sir, yours truly,
CLEMENT H. SERS.
Brighton, July 10th, 1905.

[To discuss religious beliefs is an entirely different matter from the scientific consideration of melancholia, of which religious tendencies are a marked symptom.—ED].

Obituary.

SIR WILLIAM MUIR, K.C.S.I.

EDINBURGH has lost one of its representative men in the person of Sir William Muir, who was, from 1885 to 1903, Principal of the University of Edinburgh, and a member of the Civil Service of India from 1837 to 1876, but he will probably be remembered most for the great services rendered to the University of Edinburgh during the eventful year when changes in the constitution of the Scottish colleges made by the Act (1889) led to a modification of the curriculum adopted by the Universities Commission. Sir William Muir showed a great and sympathetic interest in schemes for the welfare of the students. He received the honorary degrees of D.C.L. of the University of Oxford, LL.D. of the Universities of Cambridge, Edinburgh, and Glasgow, and Ph.D. of the University of Bologna. He died at the advanced age of eighty-six. See also notice from our own correspondent in Scotland.

JOHN GORMLEY, B.A., R.U.I., L.R.C.P. and S.ED., OF LIVERPOOL.

ON the 13th inst. the interment took place of Dr. John Gormley, one of the oldest and most respected medical men at the north end of the city. Taking his degree of B.A. at the Royal University of Ireland, he left Castlerea, his native place, to join the medical profession, and for upwards of thirty years in Liverpool the best traditions of that profession were sustained by him.

Literature.

THE DENTAL ANNUAL FOR 1905. (*a*)

THE cost of bringing out the Dental Annual must be very considerable; and if the work had not proved a great success it could hardly have survived a second year. That the third edition is more valuable than its predecessors is evident, and its greater success seems assured. This year the important question of anæsthesia is fully discussed, and a greater number of notes than in previous editions are given on materia medica and other subjects. All the leading men, a long list, who contributed monographs to the first issue have revised and brought their contributions up-to-date, and a great number of authorities who have not before written for the Annual now send valuable papers or notes on a great variety of scientific and practical subjects. The Annual is now an established institution, and needs no pressing upon the attention of dental practitioners and workers in dental science; it is moreover a directory to the profession so that it supplies useful information in a dual capacity.

MEALS MEDICINAL. (*b*)

WE have not been able to make up our minds after reading "Meals Medicinal," whether its author, Dr. Fernie, wishes us to take him seriously, or whether his treatise is an elaborate practical joke. This contribution to the science of medicine is dedicated to "Our 'Little Marys'" (playfully named); "with the Homage of a Lifetime spent in their Service"—an inscription which shows that Dr. Fernie is abreast with the humour of the day, even if his scientific acquirements are not those to which the term "orthodox" could be unreservedly applied. Of meals we learn little; of articles of diet much. The book deals, in a delightfully discursive, irresponsible way, with most of the foods, drinks, and drugs that enter the stomach of man. Dr. Fernie is so full of information of all sorts that he can never stick to one subject at a time, but roams off when discussing water to formulate theories as to the value of light-treatment, to the stories of Ruskin's disgust with his doctors, whilst he leaves us in the middle of tea to discourse upon a child's ideas of the diet of the Almighty. Of quotations the book is a mine; we catch, in turning over the leaves, citations from the following (*inter alia*):—Oliver Wendell Holmes, Virgil, Mark Twain, Robert Hutchinson, Sydney Smith, Keats, Dagonet, Pliny, Boswell, Charles Lamb, Dryden, Jane Austen, Chaucer, Lewis Carroll, Horace, Alexander Haig, Emerson, Hartly Coleridge, Pepys, Dr. Martineau, Horace Walpole, Stevenson, Ruskin, Dickens, Austen Dobson, and (need we add?) Shakespeare, and the Bible. Most of these are the reverse of *à propos*. On the other hand, there is a quantity of curious lore about the healing properties of foods and herbs, which has an interest of its own, but most of it is retailed with an air of verisimilitude that makes it difficult to judge whether or not the author adopts the ascribed virtues as his own opinions. On the whole, we are inclined to think that Dr. Fernie has no theoretical axe to grind, but is merely an irrepressible *raconteur* who must out with anything he reads or hears. And he reads and hears a good deal. It seems almost ungrateful to point out that his ideas of the value for diabetics of ordinary cream and Devonshire are the reverse of those of other authorities, or that Niels Finsen was not born in 1832, when he is stated (p. 725) to have made his famous discovery of the curative value of red light in small-pox—probably the least trustworthy of any of Finsen's observations. For anyone who wishes to throw aside the cares of practice for an hour after dinner and wander into virgin forests of odd ideas and good yarns, we can heartily recommend these amusing dithyrambic pages.

LAKE ON DISEASES OF THE EAR. (*a*)

THIS work, now in its second edition, is primarily intended for the instruction of those who propose to make a special study of diseases of the organ of hearing, and the author goes very thoroughly into the details of the various manipulations and operations which for the most part are far beyond the scope of any but a specialist. Nevertheless, the general practitioner will find therein the information that will enable him to diagnose such conditions as are amenable to direct observation, and he will derive material assistance from the numerous illustrations, especially from the three sheets of coloured plates that give a vivid idea of the lesions they depict.

Aural surgery has the reputation of being an ungrateful department of practice, but it is evident that the specialist can in suitable cases do a great deal to improve hearing, and to check the spread of aural disease to dangerous because contiguous zones. This volume, which is of moderate dimensions, and price, is a succinct guide to the pathology and treatment of ear diseases, and will be equally welcome to the general practitioner and to those who aspire to a more particular knowledge of the subject.

Literary Notes and Gossip.

THE Association for the Oral Instruction of the Deaf and Dumb, in their recently-issued report for the past year, indicate much success in their efforts to secure adequate training for teachers and instruction for children.

⁂

THE Livingstone College Year-Book for 1905 is not only an exceptionally interesting record of the work of this admirable missionary college, but it also contains hints and suggestions on health, outfit, and travel which should prove of the greatest service to all travellers.

⁂

A VOLUME of essays by Professor Osler will be published early in the autumn. It is entitled "The Fixed Period," and is said to deal fully with the question of the proper life-period in men of affairs.

⁂

THE current issue of *Climate*, the useful quarterly journal of health and travel, edited by Dr. C. F. Harford, contains a paper by Colonel T. H. Hendley, I.M.S., on "Health of Europeans in India," and an article on "Tala-azar," by Dr. Sambon.

Medical News.

Royal College of Surgeons in England.

A QUARTERLY meeting of the Council was held at the College on Thursday, the 13th inst., Mr. John Tweedy, president, in the chair. The result of the election of members of council by the Fellows of the College was reported, and Mr. Edward Owen, Mr. Rickman J. Godlee, Mr. C. H. Golding-Bird, and Mr. Harrison Cripps took their seats on the council. Mr. John Tweedy was re-elected president, and Mr. Henry T. Butlin and Mr. Edmund Owen were elected vice-presidents for the ensuing year. The following professors and lecturers were elected:—Hunterian Professors, Warrington Haward, A. H. Cheatle, H. J. Paterson, and C. G. Seligmann. Arris and Gale Lecturers, J. H. Watson and Sydney W. Curl. Erasmus Wilson Lecturer, James Sherren.

A Diploma of Membership was issued to Norman

(*a*) "The Dental Annual and Directory; a Year-book of Dental Surgery, with a Directory of the Dental Profession." London: Bailliere, Tindall and Cox, 1905. Price 7s. 6d.

(*b*) "Meals Medicinal, with 'Herbal Simples' (of Edible Parts"), By W. T. Fernie, M.D. Bristol: J. Wright and Co. 1905. 9s.

(*a*) "Handbook of Diseases of the Ear." By Richard Lake, F.R.C.S., Surgeon to the Royal Ear Hospital Second Edition, with plates. London: Bailliere, Tindall and Cox. 1904. Price 6s.

Duncan Buchanan, of Canada, and a Diploma for the Licence in Dental Surgery to Francis Sydney Doran, of Manchester. It was determined to close the Museum during August and September for repairs and redecoration.

A report was received from the Committee of Management of the Conjoint Examining Board in reference to the application of the Cairo Medical School for recognition as a place of study for candidates for the diplomas of the two Royal Colleges. The committee recommended that, subject to certain conditions, candidates who have received the diploma in medicine and surgery of the Egyptian Government, after passing the required examinations and completing the curriculum of professional study at Cairo extending over four years, be admitted to the final examination of the Conjoint Board on the completion of one year of additional study at a recognised medical school and hospital in the United Kingdom, during which they shall complete the courses required by the regulations of the Conjoint Board. The conditions provide, among other things, that an official representative of the Examining Board of the Royal Colleges be appointed annually to attend, as visitor, the examinations of the Cairo Medical School and Hospital, which are held in December and January, to take a general survey of the examinations, and to note the methods of the examiners and the standard required in each subject. The committee also reported that a communciation had been received from his Excellency the Minister of Education of the Egyptian Government expressing his complete concurrence in the conditions laid down. This report was approved and adopted by the Council, having previously received the approval of the Royal College of Physicians.

It was agreed to send an address of congratulation to the Royal College of Surgeons of Edinburgh on the occasion of its fourth Centenary Celebration.

Society of Chemical Industry.

THIS important Society, the membership of which now numbers between 4,000 and 5,000, held its annual meeting in London last week, a large number of scientific and manufacturing chemists having come over from the United States to support the president. —this year an American—Dr. H. W. Nichols, of New York.

The business part of the Congress was held in University College, in which the election of council took place, and the president delivered an address, founded on personal knowledge and experience of the management of chemical industrial organisation and research. A cordial vote having been accorded to Dr. Nichols for his address, Dr. Edward Divers, F.R.S., was inducted as president-elect.

The entire week was filled in with sessional work, receptions by the Lord Mayor and various scientific societies, banquets, excursions to Windsor, Woolwich Arsenal, Greenwich Hospital, the Royal Botanical Gardens, and was wound up by a visit on Saturday to the extensive manufacturing premises and chemical laboratories of Messrs. Burroughs Wellcome and Co., at Dartford. By a coincidence, the year 1905 happens to fall on the quarter-century of foundation both of the Society of Chemical Industry and that of Messrs. Burroughs Wellcome and Co. In a medical journal but scant reference is necessary to the firm in question, for what medical man in the civilised world does not know of its productions in the daily practice of his profession? At Dartford could be seen the laboratories whence the tabloids, the malt extract, the medical equipments for travellers, &c., emanate, but the day was a holiday, and the factory hands, as well as the Society of Chemical Industry were being entertained in commemoration of the dual event by the principal, Mr. H. E. Wellcome, with a sumptuous luncheon, to which more than fifteen hundred sat down, no fewer than thirteen hundred being employees on this gigantic establishment. After various speeches and toasts had been made and responded to by eminent members of the medical and scientific professions, the natural trend of which was towards the blending of scientific medicine with progressive pharmacy, an enthusiastic recognition was accorded to Mr. Wellcome for the munificence of his reception of the Society, and by the enormous staff of workers in testimony of the popularity and esteem in which he is held by them. The rest of the day was spent by the visitors in witnessing the sports and entertainments provided. In the evening a *recherché* dinner was partaken of by nearly two hundred specially-invited guests, among whom were many medical men and their ladies. The extensive grounds of the Wellcome Club and Institute were subsequently illuminated, and a display of fireworks closed a most enjoyable day's outing, the visitors being taken back to London by a specially provided train.

The Coombe Hospital, Dublin.

THE annual meeting of the Coombe Hospital was held on the 6th inst., the Lord Mayor in the chair. The Report stated that a total of 17,351 patients had been treated in one or other of the departments of the Hospital, and that only five deaths had occurred. The maternity department had been much improved, a suitable waiting ward and a labour theatre having been added. The number of students attending the hospital had passed all previous figures, and many past students had returned for second or third periods of work. The number of probationary nurses also remained satisfactory. Among those who took part in the meeting were the Master (Dr. Stevens), Sir John Moore, Rev. Dr. Hughes, and Dr. Neill.

Annual Meeting of the British Medical Association.

THE Seventy-third Annual Meeting of the British Medical Association will be held at Leicester on July 24th, 25th, 26th, 27th and 28th, under the presidency of George Cooper Franklin, F.R.C.S. The first general meeting of members will be held on Monday, July 24th, at 2 o'clock p.m., to be followed by the representative meeting. On Tuesday, July 25th, the representatives will resume their session at 10 o'clock, and at 2 o'clock there will be the adjourned general meeting. At 8.30 o'clock in the evening the President will deliver his Presidential Address and receive the colonial and foreign guests in the Temperance Hall, and present the Gold Medal of Merit of the Association to Sir Constantine Holman, M.D., and to Mr. Andrew Clark, D.Sc., F.R.C.S., and the Stewart Prize to Mr. Wm. Henry Power, C.B., F.R.S., F.R.C.S. On Wednesday an Address in Medicine will be delivered by Henry Maudsley, LL.D., M.D., F.R.C.P., after which the adjourned general meeting will be held to consider where the Association shall meet in 1906 and to nominate the President-elect, followed by the representative meeting. On Thursday, at 2 p.m., an Address in Surgery will be delivered by Charles John Bond, F.R.C.S.; at 3.30 p.m. the representative meeting will continue its work. At 7.30 p.m. the annual dinner of the Association will be held in the County Assembly Rooms. On Friday, at 8 p.m., a popular lecture will be delivered by Professor William Stirling, D.Sc., M.D., F.R.S.E., on "Rest and Fatigue." On Wednesday, Thursday, and Friday, from 10 a.m. to 1 p.m., the following twelve scientific sections: Medicine Surgery, State Medicine, Industrial Hygiene and Diseases of Occupation, Laryngology, Otology, and Rhinology; Navy, Army and Ambulance; Obstetrics and Gynæcology, Ophthalmology, Psychological Medicine, Pathology, Dental Surgery, Tropical Diseases will meet in the Technical Schools, the work promising to be of special interest. Much hospitality will be offered to members. On Wednesday afternoon, July 26th, the chairman of the Leicester Infirmary will give a garden party in the grounds of the Infirmary, and in the evening the President and members of the Midland Branch of the Association will give an entertainment at the Museum buildings. On Thursday afternoon there will be a garden party given by the President and members of the Leicester Medical Society in the grounds of the County Asylum and another given by Mr Maurice Levy, M.P., at Humberstone Hall. On the evening of this day the annual dinner will take place, and the Ladies' Committee has arranged an entertainment at the Grand Hotel. On Friday afternoon Mr. Samuel Faire, J.P., will give a garden party at Glenfield Frith, and there will be an excursion to Belvoir Castle, the seat of the Duke of Rutland, and also a golf match on the Leicestershire Golf Club links. In the evening the Mayor of Leicester will give a garden fête in Abbey Park. On Saturday various excursions have been arranged to Buxton and neighbourhood, and the Charnwood Forest district. On July 27th, 28th, and 29th, the cricket match between Leicestershire and Derbyshire will be in progress on the County Grounds, Leicester. The Entertainments Committee has arranged that various public works and factories shall be open for inspection to members of the Association and their friends.

The Royal Hospital for Incurables, Dublin.

The Royal Hospital for Incurables, in existence for more than one hundred and sixty years, made a new move this year in summoning the first annual meeting of its friends and subscribers. The meeting, which was held at the Hospital on the 6th inst., was well attended. The report showed that of the 213 beds in the hospital, the average number occupied through the year had been 205. Of these thirty-nine were reserved for consumptive patients, and thirty-two for cancer. The result of the treatment of consumption in the hospital showed that even among the cases classed as incurable, healthy surroundings, careful nursing, and sufficient feeding were able to cause a great improvement in health and a prolongation of life. The ordinary expenditure for the year amounted to £7,137 13s. 5d., while the ordinary income was £6,392 4s. 8d., leaving a deficit of £745 8s. 9d. to be met out of capital. During the year Dr. J. M. Finny had become consulting physician to the hospital in room of the late Dr. Cranny. Among those who spoke at the meeting were Mr. William Fry, Junr. (chairman), the Lord Mayor of Dublin, Sir George Roche, and Mr. Maurice Dockrell.

Trinity College, Dublin.

List of successful candidates during Trinity Term, 1905." Previous " Medical Examination.

Anatomy and Institutes of Medicine.—William S. Thacker, Johannes C. Pretorius, Wilfred J. Dunn, and Frederick Stevenson, eq., David J. Miller and Allman J. Powell, eq., Charles H. O'Rorke and Edmond H. Sheehan, eq., James C. C. Hogan, Henry de C. Dillon and Thomas P. Dowley, eq., Denis J. Stokes, John A. L. Hahn, Albert V. J. Richardson, James R. Yourell, William Knapp, and James D. K. Roche, eq., Ernest N. Ryan and William H. Sutcliffe.

Physics and Chemistry.—Thomas A. Hughes, Arnold K. Henry, Albert Stals, John D. Kernan and Perceval G. Leeman, eq., William S. S. Boxwell, Charles G. S. Baronsfeather, Peter H. Lemass, James Alston, Louis Trichard and William R. Watson, eq., Charles H. Denham, Hubert G. Holdbrook and Robert E. T. Tatlow, eq., Adams A. M'Connell, John C. Baker and Ernest Jameson, eq., Frank Smartt and Alexander S. M. Winder, eq., Gervase Scroope, Alfred H. Smith.

Botany and Zoology.—Arnold K. Henry, David L. M'Cullough, Beatrice M. Hamilton, Thomas A. Hughes and Cecil P. Smyly, eq., Perceval G. Leeman and William P. H. Smiley, eq., George Eliot, James H. Crane and William R. Watson, eq., Edward P. Allman-Smith and Hilgard Müller, eq., Adams A. M'Connell, Marius A. Diemont, John Gardiner, and Henry H. Ormsby, eq., Euphon M. Maxwell and Eric J. Powell, eq., John D. Kernon, Victor G. Best and William A. Taylor, eq.

John Mallet Purser Medal.—Johannes C. Pretorius.

The following were successful at the Medical Scholarship examination (Trinity Term, 1905) :—

Anatomy and Institutes of Medicine.—William Pearson, Trin. Coll. Scholarship; Robert E. Wright, Stewart Scholarship.

Physics, Chemistry, Botany and Zoology.—Richard P. Hadden, Trin. Coll. Scholarship; Hugh R. M. Ferguson (Sch.), Stewart Scholarship.

University of Glasgow.

The following have satisfied the Examiners in the fourth (final) professional examination for M.B., Ch.B. :—

Andrew Blair Aitken, George A. Allan, William S. Allan, Andrew Allison, Andrew W. Anderson, John Bain, M.A.; Annie A. Baird, M.A., James H. Baird, B.A., Hugh Barr, Andrew F. Bell, Ethel L. Chapman, Jeannie T. Clark, Robert W. Dale, M.A., David W. Davidson, Robert S. Dewar, M.A., Hugh M'M. Donaldson, Allan C. Douglas, John S. Dunn, M.A., Eric J. Dyke, Hamilton W. Dyke, Alexander B. Ferguson, Mary T. Gallagher, William Gilchrist, William H. Gillatt, William M. Gilmour, Joseph Glaister, Louis L. Greig, William Grier, Alexander R. F. Hay, James W. Hay, Ralph V. Howell, John M. Huey, James Hunter, Harry S. Hutchison, B.Sc., Arthur Innes, William B. Jack, Arnold E. Jones, Robert D. Kennedy, William L. Kirkwood, Alexander L. George Hugh Logan, William Logie, John B. M'Cabe, Walter G. Macdonald, M.A., Duncan M'Ewan, Hugh A. Macewen, Robert M. Macfarlane, James D. Macfie, Milne M'Intyre, John M'Millan, Peter Maguire, William B. M. Martin, Robert May, Henry J. Milligan, Macdonald Munro, Frank A. Murray, John D. Nisbet, David Panman, Henry S. Ranken, Cunison D. Rankin, Thomas T. Rankin, John Reid, James M. Renton, William Rolland, Alexander C. Russell, Frank D. Scott, Jane R. Shaw, Lily Smellie, James A. Somerville, Arthur A. Stewart, Daniel Stewart, John L. Stewart, M.A., William A. Stuart, Joseph R. Sutherland, Elizabeth T. Talbert, John Taylor, William L. Walker, M.A., Robert Wallace, Alexander McM. Watson, Archibald C. West, Archibald S. Wilson.

The following passed with distinction in the subjects indicated :—

In (*a*) Surgery and Clinical Surgery, (*b*) Practice of Medicine and Clinical Medicine—Jeannie T. Clark, Peter Macquire. In (*a*) Surgery and Clinical Surgery; (*b*) Midwifery—James H. Baird, B.A. In Surgery and Clinical Surgery—Hugh A. Macewen. In Medicine and Clinical Medicine—George A. Allan, Andrew Allison, John S. Dunn, M.A., Arther Innes, William B. Jack, Cunison D. Rankin, John L. Stewart, M.A. John Taylor.

Royal College of Surgeons in Ireland.

Fellowship Examinations.

Mr. Michael Ulick O'Sullivan, L.R.C.S.,Edin., &c., having passed the necessary examination, has been admitted a Fellow of the College.

Royal College of Physicians and Surgeons (Ireland).

The following candidates have passed the second Professional Examination as undernoted : —*With Honours*—T. C. Boyd. J. C. L. Day, J. Murray, T. J. M'Donnell, W. G. Ridgway. *Arranged in Alphabetical Order*—P. H. Black, T. P. Cormack, P. J. Cusack, J. J. Cuskelly, G. A. Finegan, J. P. Grainger, F. N. Holden, S. W. Hudson, C. Hyland, P. MacCarthy, M. J. Saunders, A. Sheridan, P. J. Timoney.

St. Mary's Hospital, London, has received a bequest of £2,000 from the executors of Mr. J. H. Lucking towards the £17,000 additional income required to maintain the work of the hospital during the present year.

The Secretary of State for India has received the following telegrams, dated July 8th, in regard to the plague :—" Deaths from plague reported in places outside Bombay Presidency in June last : Madras Presidency, 41 ; Calcutta, 160 ; Bengal (excluding Calcutta), 936 ; United Provinces of Agra and Oude, 2,258 ; Punjab, 21,601 ; Burma, 416 ; Central Provinces, 6 ; Mysore State, 124 ; Hyderabad State, 11 ; Rajputana, 556 ; Kashmir, 95. No plague reported elsewhere.

On Wednesday last, her Royal Highness the Duchess of Argyll opened the buildings for epileptic children at the Colony of Mercy, Lingfield, Surrey. These homes are intended to receive poor epileptic boys and girls whose maintenance is assured by Boards of Guardians and other private bodies.

Notices to Correspondents, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

COUNTRY DOCTOR.—Your story is not incredible. Ignorance on these points among the poor is astonishing. A labourer near Brighton is reported to have become indignant at the comments of a doctor on a tuberculous pig, and to have said that an animal like that was tastier. "We never kill a pig of his sort till he coughs, then we know the flesh is soft."

DR. F.—Quacks often advance as proof of their "electric" power the exhaustion that follows in themselves after massaging, whereas the most efficient worker is he who uses no more strength than is needed and is not exhausted by any amount of work which an ordinary man could get through. The personal requirement is physical strength, trained to do the will of a trained mind.

ALIENIST.—The X-Rays in epilepsy were first tried three years ago, upon the theory that epilepsy depends upon the instability of the, cellular brain elements, and the X-Rays stimulate protoplasm into greater activity. On the other hand, serious mental disturbance has been attributed to the action of the Rays. Manders claims that one in every thousand in Europe is epileptic.

DR. S. H. (Hull).—Roentgen's experimental works are published in *Annalen der Physik und Chemie*. He was born at Lennep in 1845, and graduated at Zurich.

L.S.A.—There were over 130 applicants for medical posts in connection with the London County Council, and twenty applicants were selected.

BABY-BOY TABLOIDS.

IN his speech at Dartford on Saturday last, at the luncheon given in honour of the president and members of the Society of Chemical Industry, Mr. Hy. S. Wellcome said that among the many requests for Tabloids received from various parts of the world came a not uncommon one for "Baby-boy Tabloids," if, as was sometimes added, it was not an illegal act to use them.

MAB.—Your question does not appeal to the medical profession, therefore we cannot insert it in our columns. Try one of the lay journals.

KERATITIS.—As far as we can judge from your statement your conduct was professionally correct.

JUDGE.—We have not heard any thing relating to your complaint.

M.D.EDIN.—The Society is progressing very favourably.

PATH.—The subject will no doubt be brought forward at the ensuing meeting of the British Medical Association.

A COUNTRY MEMBER.—The last meeting of the session was held on the 13th inst., we hope to publish the report in our next.

A. S. WESTON.—The report referred to is of American origin, we cannot vouch for the truth of the statements therein made; to us they appear not only incredible, but practically impossible,

A SCOTCHMAN.—The fees are somewhat less at some of the Scotch Colleges, than they are either at the English or Irish Colleges.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 19th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5.30 p.m. Annual General Meeting. Election of Office Bearers and Report of the Council.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. J. Pardoe: Clinique. (Surgical.) 5.15 p.m. Mr. A. Lane: Abdominal Surgery.

THURSDAY, JULY 20th.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Lecture:—Dr. H. Scharlieb: Some Post-anæsthetic Complications. (Post-Graduate Course).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. W. E. Miles: Neoplasms of the Rectum and Anus.

Vacancies.

The Victoria University of Manchester.—Junior Demonstrator in Physiology. Salary £100 per annum. Applications to the Registrar.

The Hospital for Consumption and Diseases of the Chest, Brompton.—Resident Medical Officer. Salary £200 per annum, with board and residence. Applications to the Secretary, at the Hospital. Frederick Wood, Secretary, Brompton.

Borough of Leicester—Education Committee.—Medical Officer. Salary £400 per annum. Applications to T. Groves, Secretary, Leicester.

The Grocers' Company's Scholarships.—Salary £300 per annum. Applications to the Clerk of the Grocers' Company, Grocers' Hall, London, E.C.

Parish of Hammersmith.—Infirmary Medical Superintendent and Workhouse Medical Officer required. Salary £250 per annum, with unfurnished house, coals, light, and washing. Applications to J. Lamb, Clerk to the Guardians, Guardians' Offices, 206 Goldhawk Road, Shepherd's Bush, W.

Royal Berkshire Hospital, Reading.—Secretary and House Governor. Salary £200 per annum, with residence Applications to the Secretary.

The Royal National Hospital for Consumption, Ventnor.—Senior Resident Medical Officer. Salary £200 per annum, with board and lodging in the Hospital. Applications to the Secretary, 34 Craven Street, Charing Cross, London.

Dorset County Hospital, Dorchester.—House Surgeon. Salary £100 per annum. Applications to W. E. Groves, Valetta, Icenway Dorchester.

Wallasey Dispensary and Victoria Central Hospital, Liscard.—House Surgeon. Salary £100 per annum, with good apartments, board, and service.—Applications to Mr. E. Russell Taylor, Kingscourt, Liscard, Cheshire.

Weston-super-Mare.—House Surgeon. Salary £100 per annum, with board and residence in the Hospital. Applications to the Honorary Secretary.

Royal City of Dublin, Hospital.—Pathologist, Anæsthetist, X Rayist and Dentist. Immediate applications to the Hon. Secretary, Medical Board.

Appointments.

BALL, JOHN BRAMLEY, L.D.S.R.C.S.Eng., Dental House Surgeon to Guy's Hospital.

BURNET, R. W. M.D.Aberd., F.R.C.P.Lond., Consulting Physician to the Great Northern Central Hospital.

FORTY, ARTHUR ALAN, L.D.S.R.C.S.Eng., Dental House Surgeon to Guy's Hospital.

HEWKLEY, FRANK, M.B.Durh., F.R.C.S.Eng., Honorary Physician to the St. Pancras and Northern Dispensary.

SYMES-THOMPSON, H. E., M.D., M.R.C.P.Lond., Physician with charge of out-patients to the Great Northern Central Hospital.

TRENFIELD, GEORGE HENRY, L.R.C.P.Lond., M.R.C.S., Surgeon to the Midland Railway at Bristol.

WATERHOUSE, RUPERT, M.D.Lond., M.R.C.S.Eng., Pathologist and Curator of the Museum at the Royal United Hospital, Bath.

Births.

BOURNE.—On July 15th, at Bridge House, Halling, Rochester, the wife of H. J. F. Bourne, L.R.C.P., of a daughter.

MISKIN.—On July 12th, at Slade House, Kennington Road, London, the wife of Ernest Miskin, M.B.Lond., of a daughter.

Marriages.

GIBSON—FLOWER.—On July 15th, at St. John's Chapel, Melbourne, Frederick Goulborn Gibson, M.D., of Christchurch, New Zealand, to Dorothy Mary Flower, only daughter of James Flower, of Basildon, Bexley, Kent.

KLUMPP—CRAWFORD.—On July 12th, at St. James' Church, Kidbrook, Ernest George Klumpp, M.B., of Wootton Bassett, Wilts., to Dora Elizabeth, daughter of Colonel Crawford, Royal Artillery (retired), of 13 Kidbrook Park Road, Blackheath.

TRINDER—CROOKES.—On July 1st, at Bembridge, I.W., Alfred Probus Trinder, M.R.C.S., L.R.C.P., to Constance Rose Nellie Crookes (née Masenilli).

WITT—WATTS.—On July 15th, at St. George's, Hanover Square, Tansley, third son of the late Charles Witt, M.D., to Gertrude, widow of Colonel John Germain Watts, India (Bombay) Staff Corps, and only daughter of John Macdowell Hay.

Deaths.

GABE.—On July 16th, at Westwood, Ashby de la Zouche, Leicestershire, Grace Winifred, the dearly beloved wife of John Rees Gabe, M.D., M.R.C.S.Eng., of 16 Macklenburgh Square, London.

KAY.—On July 17th, at Bentley Cottage, Bentley, Hants, Mary, Ellen (Lillie), the beloved wife of William Kay, M.R.C.S., L.S.A

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, JULY 26, 1905. No. 4.

THE OPERATIVE TREATMENT OF RECTAL CANCER.

POST GRADUATE LECTURE. (*a*)

By EDWARD H. TAYLOR, M.D., UNIV. DUB., F.R.C.S.I.,
Deputy Professor of Surgery, Trinity College, Dublin; Surgeon to Sir Patrick Dun's Hospital.

GENTLEMEN,—As I have had to deal with a considerable number of cases of cancer of the rectum in the course of the past eighteen months, I thought the present occasion would be very suitable for demonstrating to you the results which can be obtained by operation under favourable conditions, and explaining the particular form of operative procedure which I now employ. I must preface my remarks, however, with a very brief allusion to certain facts concerning the anatomy of the rectum. Nowadays, we assign as the limits of this segment of the bowel the level of the lower border of the third sacral vertebra above, the anal orifice below, and we further subdivide it into two parts, viz., an upper or intrapelvic part, the rectum proper, and a lower or extrapelvic part, the anal canal. Only for about half of its extent has the rectum any relationship to the peritoneum, and that of a limited character, viz., in front and on each side. From the level at which the membrane leaves it down to the commencement of the anal canal, the rectum is invested in both sexes by loose tissue containing a variable amount of fat together with the hæmorrhoidal blood vessels, nerves, lymphatics, &c., enclosed within what I may call its sheath of pelvic fascia, *i.e.*, the recto-vesical fascia in front separating it from the bladder, seminal vesicles, and prostate in the male, from the vagina in the female, and the rectal fascia behind, separating it from the sacrum and coccyx (Fig. 1). This fascial sheath possesses very great significance in connection with excision of the rectum. In approaching the bowel from behind after the coccyx and part of the sacrum have been removed, the rectal layer just mentioned will be encountered and should be divided freely in the vertical direction before the rectum is sought for. I regard this apparently trivial detail one of no small importance as its omission would be very apt to lead to difficulty in the further stages of the operation. For instance, an operator oblivious of this fact, thinking he is in immediate contact with the rectum after the bone is removed, would probably expend his efforts for some time in merely detaching the pelvic fasica from the front of the sacrum upwards to a very undesirable extent. By opening the fascial sheath of the bowel promptly the perirectal fatty tissue is at once exposed, and the rectal wall identified.

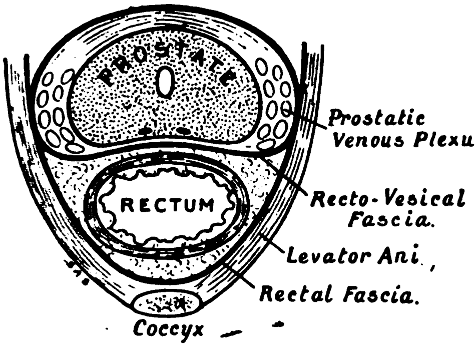

FIG. 1.—Diagrammatic representation of the pelvic fascia in its relationships to the rectum.

With the limits which I have just assigned to the rectum, it is possible in nearly all cases by a digital examination to detect a malignant growth in its interior. Growths which are entirely out of the reach of the finger, especially if the examination be made with the aid of anæsthesia, must be regarded as being situated not in the rectum proper, but in the pelvic colon.

In the cases which I am about to demonstrate the disease was for the most part confined to the rectum. In some the pelvic colon was involved to a slight extent, but in none was the sphincteric zone encroached upon. In all the plan of operation which I carried out was the same, and as this differs in many respects from the methods usually described, I propose to devote the remainder of the lecture to the description of its details, and the results generally which I have obtained.

There are just two matters, however, to which I must refer before entering upon the operative details. The first of these is the selection of suitable cases for operation. Extension of the growth beyond the peripheral confines of the bowel, but more especially in front should be regarded as a distinct contra-indication. The best way for roughly determining the local extent of the disease is to introduce the examining finger through the stricture, if one exists, or to the upper border of the growth if this involves but a part of the circumference of the bowel, and by drawing the mass down towards the anus, observe how far the rectum retains its natural mobility. Immobility of the diseased segment and marked rigidity of the surrounding tissues indicate extensive local infiltration, and point strongly against excision being attempted. The normal range of mobility of the rectum in the vertical direction varies within fairly wide limits. In one patient a digital examination will reveal great laxity of the perirectal tissues, as evidenced by the facility with which the growth moves up and down with the finger engaged within the bowel. I always regard this as a most hopeful sign, as it enables one, among other things, to form a fairly correct estimate of the ease with which the pelvic colon will descend in the course of the operation. In another patient with possibly quite a limited amount of disease one may fail to get much evidence of mobility, and the probability is that in such a case considerable difficulty will be encountered in drawing down the pelvic colon to the level of the anus. I have noted

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(*a*) Delivered in Sir Patrick Dun's Hospital, June 19th, 1905.

this difficulty in males more frequently than in females, and in stout persons more constantly than in those of spare build.

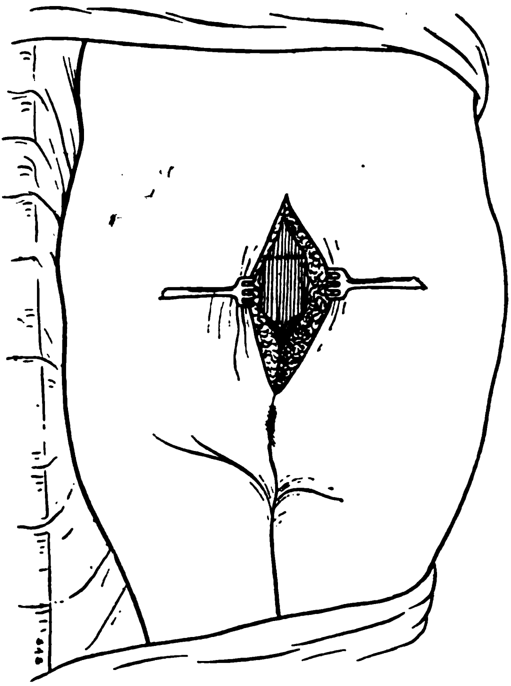

FIG. 2.—Position of patient in the operation of trans-sacral excision of the rectum.

The second point to which I would direct your attention is the necessity for careful preparatory treatment. Very often patients suffering from rectal cancer experience progressively increasing difficulty in securing a free evacuation of the bowels. Now, above all things, this is a matter which must be attended to; indeed, its importance cannot be over-estimated. My practice is to devote some days towards attaining this end. Large doses of castor oil serve the purpose admirably. I find it well to administer about three doses altogether, at intervals of forty-eight hours, or the first dose of oil may be followed in forty-eight hours by two ounces of black draught, and later on by another dose of oil. During this period the patient's diet consists of fish, milk, thick soups, eggs beaten up, &c., and no food is permitted which would be calculated to leave much residue in the bowel. Unless a marked degree of stricture is present the bowel is washed out each evening with weak boracic solution. Twenty-four hours before the operation the patient is given opium in the form of Pil. saponis, grs. v., and the same dose is repeated at intervals of four hours until three or four pills have been taken. This ensures a quiescent state of the bowels both during and for some time after the operation, and as we shall see, this means a great deal in promoting a smooth and uneventful convalescence.

Let us now pause for a moment to consider wherein consist the principal points of difference between the rectum, and the other sub-divisions of the large bowel, at least so far as the operation of resection is concerned. The principal are as follows:—The rectum is more fixed, with a partial investment of peritoneum; its blood vessels run vertically to its long axis instead of at right angles as is the case with the intestinal vessels higher up. The principal vessels are the superior hæmorrhoidal, the two main divisions of which descend upon the posterior and lateral aspects of the bowel. Upon the integrity of these vessels its vitality mainly depends, and consequently they must be treated with very great circumspection. Finally, the rectum at its termination is provided with a highly co-ordinated sphincteric apparatus, and it should be one of the great aims of the operation of excision to leave it intact and capable of carrying on its normal functions.

In anticipation of what is about to follow, I may mention that end-to-end junction of the healthy segments of the rectum after excision is not at all satisfactory. Not alone is it a difficult matter to bring the bowel edges neatly and accurately into apposition, but the suturing process is greatly hampered if attempted through the sacral wound, and even if one were to succeed in carrying it out the failure of union would be very apt to occur as the opposing surfaces devoid of peritoneum to a large extent, if not entirely, do not lend themselves to rapid union. Furthermore, even if an attempt at union were to take place, the resistance offered by the undivided sphincters would result in severe strain on the suture line, and very possibly rupture followed by fæcal extravasation into the pelvic cellular tissue. Apart from the immediate danger of sepsis with its possibly fatal consequences, such an accident would most likely entail the establishment of a fæcal fistula in the sacral region which would need to be closed later by a second operation.

THE OPERATION.—The patient having been anæsthetised by nitrous oxide gas and ether, I first wash out the rectum as thoroughly as possible. I employ boracic solution for this purpose, and take care to ensure that all the fluid injected comes back again. The lower part of the rectum and the seat of disease

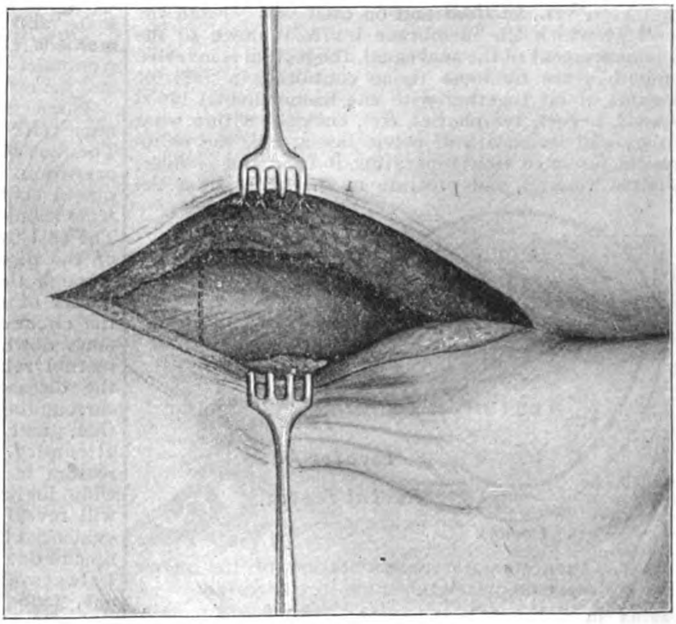

FIG. 3.—This figure represents the extent of the superficial incision. The line of bone section appears as a double dotted line, and below the tip of the coccyx the levatores ani muscles, together with the ano-coccygeal raphé, are indicated in the depth of the wound.

are then wiped dry with some muslin swabs or pledgets of absorbent wool held in forceps. I always wear rubber gloves during this washing-out process, and change them for another sterilised pair before proceeding further with the operation.

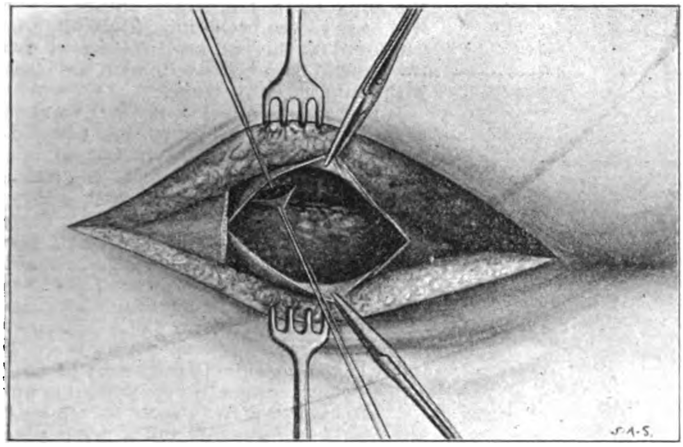

Fig. 4.—In this figure, the coccyx and lower part (¾ in.) of the sacrum have been removed. The divided margins of the rectal pelvic fascia are held aside with forceps and the pelvic cavity has been opened into. Traction loops of silk separate the margins of the peritoneal aperture.

The patient is now placed upon the left side with a small air cushion protected by a mackintosh beneath the great trochanter. The buttocks are brought on a line with the edge of the table, and the knees are well drawn up. The skin is disinfected as thoroughly as possible, and an incision about five inches in length is made exactly in the middle line from near the middle of the sacrum to within an inch of the anus. The wound is rapidly extended through the subcutaneous tissues until the coccyx and lower part of the sacrum are exposed. By moving the tip of the latter backwards and forwards one readily perceives the level of the sacro-coccygeal articulation provided it is not ankylosed. I now measure off a piece of the lower end of the sacrum about ¾-inch in extent by laying my middle finger across the bone immediately above the joint line and drawing a scalpel across the tendinous structures at this level (Figs. 2 and 3). The tissues attached to the bone below this are divided on each side, the osseous section is completed, an Adams' saw answering admirably for the purpose, and the coccyx and lower part of the sacrum are removed. In addition to some small branches of the sciatic artery which require the application of hæmostatic forceps, the middle sacral artery is divided and is sometimes a little difficult to secure owing to its very close connection with the front of the sacrum. The rectal layer of the parietal pelvic fascia is next identified, picked up and divided between catch forceps. It is advisable also to extend the incision downwards for a short distance into the ano-coccygeal raphé between the levatores ani (Fig. 3). The next step in the operation I regard as the real key to the situation, viz., the isolation of the diseased segment of the bowel. Some operators adopt the plan of first dividing the gut below the diseased part and then proceed to separate it from below upwards, but I do not think this wise, because the division is almost certain to be accompanied by tearing of the rectal wall, and contamination of the wound with matter from within the bowel. I much prefer to obtain command of the latter above the disease, and subsequently to proceed with the excision. Further I have no doubt whatever that the best way for accomplishing this is to open into the cavity of the peritoneum (pararectal fossa) without delay. This is most readily done by snipping through the perirectal fatty tissue between catch forceps just below the divided sacrum and about half an inch to the right of the bowel wall (Fig. 4). If the tissues are divided too close to the latter there would be considerable danger of wounding the corresponding main division of the superior hæmorrhoidal artery. The right index finger is now introduced into the pelvic cavity through the peritoneal aperture, and made to project on the opposite side of the bowel, where it can be cut down upon and pushed through. It is an easy matter then to pass a strip of gauze around the rectum to serve as a traction loop. A limited division of the fatty tissue behind the rectum and of the lateral peritoneal reflection on each side permits of a fairly extensive stretch of bowel being drawn up into the wound, indeed it is often surprising how readily the pelvic colon comes down when its mesentery is thus partially divided. Of course, a free division of this structure would be dangerous owing to the risk of wounding the hæmorrhoidal vessels. If any doubt now exists as to the exact position of the upper limit of the growth an assistant introduces his finger into the rectum and indicates a point fully an inch above the diseased area. A stout silk ligature is applied here and tied as tightly as is possible. Another ligature is similarly applied still higher up, whereupon the bowel is cut across between the two, carefully wiped dry, and disinfected, as well as can be, with liquid carbolic acid or the cautery. Before proceeding with the dissection further a good plan is to fix the upper bowel segment temporarily to the skin of the buttock as shown in Fig. 5.

The separation of the lower or diseased segment

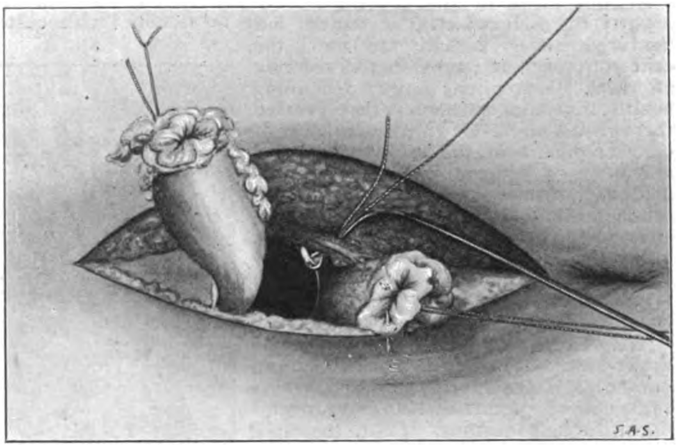

Fig. 5.—The bowel has been divided between silk sutures above the growth. The upper segment is fixed temporarily to the skin of the buttock, while the lower is being separated from its surroundings. The aneurysm needle threaded with catgut has been passed beneath the middle hæmorrhoidal artery. Note the line of peritoneal division represented in the figure below the eye of the needle.

does not usually present much difficulty. In front the peritoneum at the recto-vesical or recto-vaginal reflection, as the case may be, is divided, and then with the help of the index finger or a blunt dissector the bowel is separated from the bladder and prostate in the male, from the vagina in the female. On each side the so-called "lateral ligaments" of the rectum containing the middle hæmorrhoidal vessels are ligatured with catgut—I employ this material for all ligatures in this operation (Fig. 5). By snipping through the perirectal tissues on each side with blunt-pointed scissors the rectum is separated from its connections quite down to thec ommencement of the anal canal.

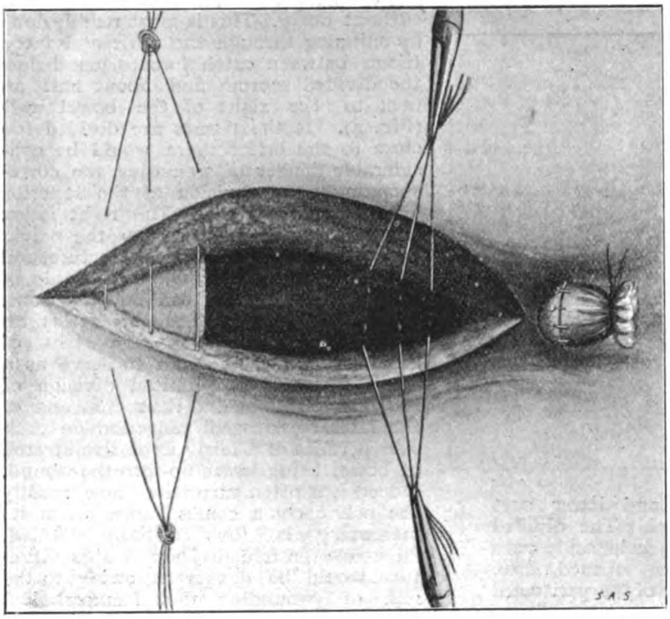

Fig. 6.—The upper segment of the bowel occluded by a silk ligature has been drawn down through the anus and connected to the everted mucous membrane of the anal canal by a series of interrupted sutures. The deep sutures connecting the levatores ani muscles are shown in situ.

At this stage of the procedure two alternatives present themselves: 1. The rectum may be doubly ligatured below the disease and the cancerous segment removed, tied securely at each extremity; the remaining healthy mucous membrane is then everted through the anus. Or 2. The entire cancerous segment of the rectum, occluded above by a ligature, may be invaginated, *i.e.*, turned inside out and made to protrude through the anus. It is possible to do this if the growth is not bulky, and it is certainly to be recommended, as it enables one to thoroughly inspect the diseased area and make the lower section with ease and precision.

The temporary suture retaining the upper segment (Fig. 5) is now undone and one notes if the laxity of the latter is sufficient to permit of its being drawn down through the anus. If not, the fatty tissue behind the bowel may be still further divided, preferably by blunt dissection, and the peritoneum on each side of the mesentery snipped with scissors. While this is being done one should carefully examine for lymphatic glands, and remove any which may be felt or seen. Before drawing down the ligatured bowel through the anus it is advisable to suture its anterior or serous aspect to the divided peritoneum of the recto-vesical or recto-vaginal pouch (Fig. 5). The next step consists in connecting the everted mucous membrane of the lower part of the rectum to the side of the bowel which has been made to emerge at the anus, as is represented in Fig. 6. A useful precaution also at this stage is to connect the ligatured extremity of the gut to the skin in the vicinity of the anus by a temporary suture. The free ends of the occluding suture may be employed for this purpose. This prevents the parts slipping back and receding within the anal aperture.

It now remains to close the large wound in the sacral region. It is well to introduce a few deep sutures of catgut first through the musculature of the pelvic diaphragm, and the rectal wall. These sutures serve to take the strain off those already introduced at the anus, and prevent the bowel slipping back. Finally the greater part of the wound is closed with silkworm gut and a couple of strips of iodoform or xeroform gauze are introduced for drainage purposes as there is likely to be a considerable amount of sero-sanguineous oozing after the patient is put to bed (Fig. 7). The gauze is removed after forty-eight hours and a fresh plug introduced.

As it is desirable to keep the bowels constipated for some days after the operation, the administration of opium is continued. Pil. plumbi c. opio answers very well. The protruding extremity of the bowel is inspected from time to time to see if there is any evidence of gaseous or fæcal accumulation above the ligature. As a rule there is no need to interfere with this for at least three days. If necessary, a small puncture may then be made and flatus allowed to escape. By this time the opposing peritoneal surfaces have acquired adhesions, the pelvic cavity is sealed up and the protruding bowel has become securely anchored in its new site. If after removal or spontaneous separation of the ligature the parts do not recede gradually within the grasp of the sphincter, they may be trimmed with scissors, bleeding points being ligatured with catgut, but this is seldom necessary. At the end of a week or ten days the bowels are made to act freely with castor oil.

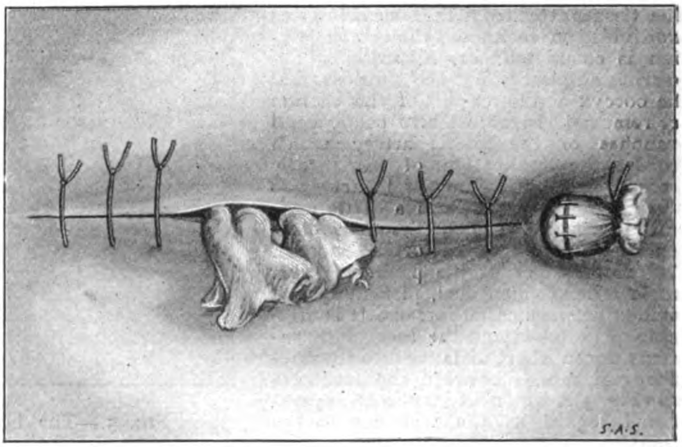

Fig. 7.—View of the completed operation. The sacral wound is not completely closed by suturing, but is left partly open and packed lightly with iodoform or xeroform gauze.

I shall now demonstrate to you some specimens of rectal cancer which I have removed by this method. As to the results you can judge for yourselves.

CASE I.—The first to which I shall direct your attention is that of an elderly man (J. H.), past seventy, who was sent to me by Dr. Hamilton, of Arklow. Before his admission to hospital he had had increasing trouble in getting his bowels to act for several months. He experienced little pain, but an abundant discharge of clear mucus, which escaped involuntarily per anum and soiled his clothes, caused him great annoyance. On digital examination a large mass of growth could be felt; it extended to within about two inches of the anus, but it was possible to feel healthy bowel above it. The growth lay posteriorly, and did not interfere with the normal mobility of the rectum. It is now sixteen months since the excision was performed, and this specimen (Fig. 8) which I removed on that occasion represents a well-marked type of rectal cancer, *i.e.*, an irregular mass of cancerous growth projects prominently into the lumen of the bowel. The patient, who has been good enough to attend here to-day for your edification, is now in perfect health. On introducing a finger into his rectum you will detect a faint ridge immediately above the commencement of the anal canal which indicates the level of bowel junction. Observe that there is not the least evidence of stricture or narrowing here, and that the resistance of the sphincters is perfectly normal. He has completely lost his cachectic appearance and is now in the enjoyment of excellent health.

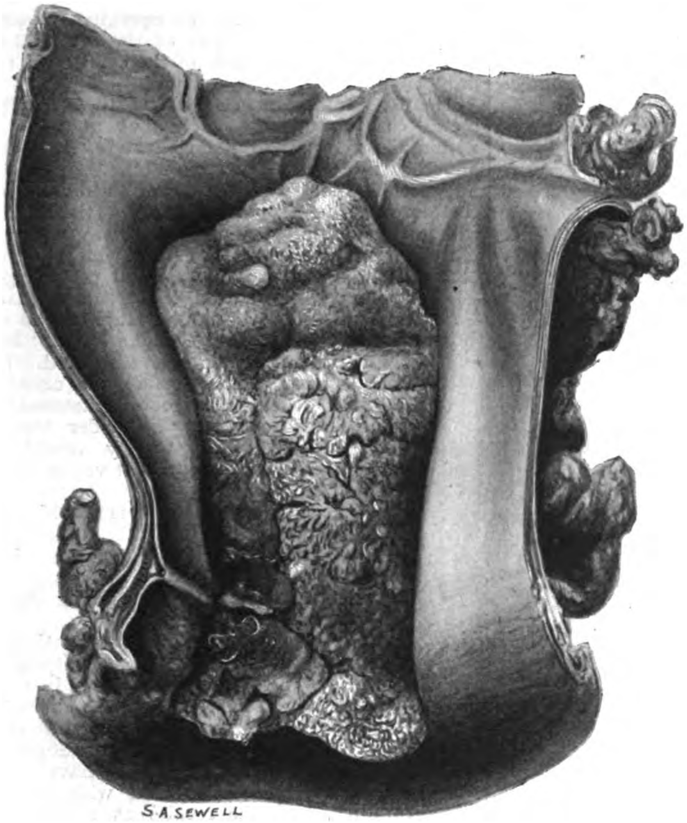

FIG. 8.—Cancerous growth involving the rectum removed by the trans-sacral operation. Case I.

CASE 2.—The next case is that of a woman, Mrs. L., æt. 65. She was transferred to my charge early in June last year by my colleague Dr. Finny. On examination I detected a soft cauliflower growth in the rectum, its upper limit being just within reach of my finger. It was situated for the most part posteriorly, and was well above the sphincters. Some few days later I removed the affected segment of the bowel exactly as I have described. You will see in it (Fig. 9) another type of rectal cancer occasionally met with. A raised mass of cancer growth, for the most part flat on the surface, extends over a considerable area of the rectal wall. In some places its edges are prominent and overhanging, in others they slope away imperceptibly into healthy mucous membrane. Before undertaking the operation I was struck with the very free mobility of the rectum as ascertained by digital examination. The correctness of this observation I subsequently confirmed as I experienced but little difficulty in the actual excision and in the subsequent drawing down of the pelvic colon through the anal aperture.

You will notice an interesting fact on examining this patient, now twelve months after operation. She has developed a small hernial protrusion in the sacral region. This she attributes to a severe attack of bronchitis from which she suffered during the winter months, but it does not cause her much annoyance. On digital examination, as in the last case, you will detect a barely perceptible cicatricial ridge marking the line of junction of the two bowel segments. There is absolutely no evidence of stricture and she has perfect sphincteric control. I may mention also that she has gained considerably in weight.

CASE 3.—The third and last case which I purpose bringing under your notice to-day is that of an old man,

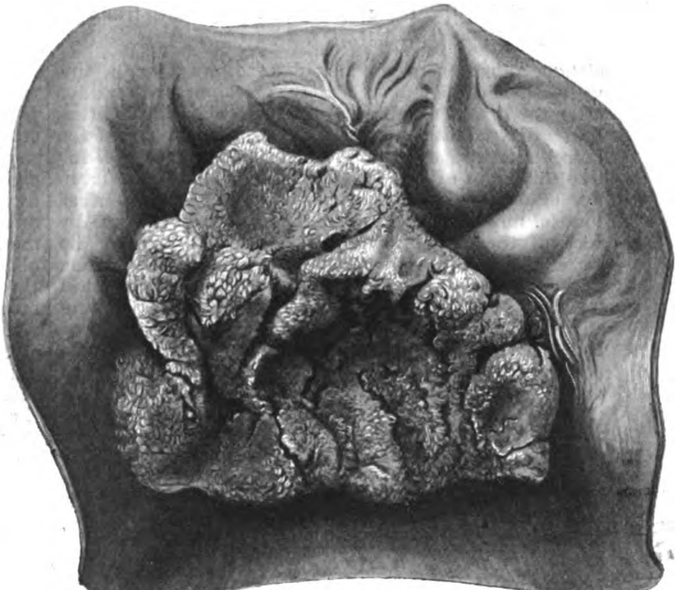

FIG. 9.—Cancerous growth of rectum excised by the trans-sacral operation. Case II.

N. S., æt. 72, who was sent to me from the out-patient department by Dr. E. J. Watson. On examination I found a hard mass of malignant growth extending completely around the rectum narrowing its lumen to a very marked extent. It is a good example of the annular type of cancer (Fig. 10). Such a growth is very apt to cause obstructive symptoms as it leads to stenosis of the lumen of the bowel of a progressive character. It is in such cases also that one is most likely to encounter difficulty in promoting a free evacuation of the bowels before operation. The upper part of the stricture in the present instance could just be reached by the finger, but it required an effort to do so. The mobility of the rectum was limited, but nevertheless it was sufficient to reassure me that excision was possible.

The steps of the operation, which was performed thirteen months ago, were precisely similar to those which I have described, but I experienced considerable difficulty in rendering the pelvic colon sufficiently lax to enable it to reach the anus as its mesentery, although free from obvious disease, was tough, unyielding, and loaded with fat. Some four or five days after the operation on removing the occluding ligature I was disappointed to find the lower extremity of the bowel necrotic posteriorly. This I attributed to a too free division of the hæmorrhoidal blood-vessels in my efforts to bring down the bowel. As the fæces for the most part from this time onwards escaped by way of the sacral wound, I decided to extend the latter through the sphincters into the anus. The healing process continued to progress satisfactorily, but I noticed that the upper bowel segment receded gradually, so that its discharging orifice came to lie hidden beneath the divided sacrum. A few months later the patient returned to me, complaining of want of control over the bowels, and a scalding sensation referred to the skin in the vicinity of the sacral wound. Yielding to his entreaties to do something to improve his condition I dissected the bowel free from its surroundings, opening the pelvic peritoneum in doing so, and drew it down without much difficulty to the anus, where I fixed it by sutures, having first vivified the parts here. Then, having pared and undercut the margins of the skin wound and freshened the edges of the sphincter behind, I brought the parts together so as to cover in the posterior aspect of the bowel and re-establish the normal condition of parts in this region. I am happy to say the result of this second operation has exceeded my expectations. The patient, as he himself will tell you, is in a much more comfortable condition; his control, although not perfect, is nevertheless good, except after taking medicine, when the motions assume a liquid character. On examining the bowel with the finger you will find it quite healthy, and the anal region in a sound condition.

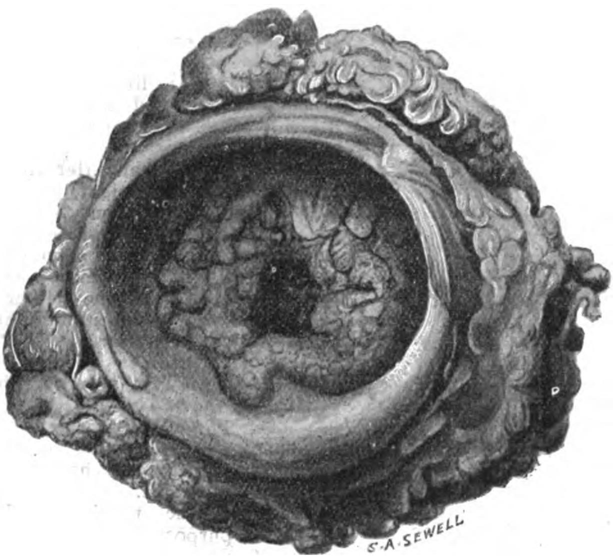

Fig. 10.—Annular variey of cancerous growth involving the rectum, removed by the trans-sacral operation. Case III.

I had hoped to have had two other cases to exhibit to-day, in both of which the operative results have been most satisfactory, but as the individuals concerned live in remote parts of the country, I found i impossible to carry out my intention.

There are many points relative to the surgery of rectal cancer which I could not possibly include within the compass of a single lecture. You doubtess have heard of other operative methods, but time does not permit me to review them in detail. I shall therefore conclude by summarising the main facts which I would like you to carry away with you.

1. Of the cases of rectal cancer which come under observation, a comparatively small percentage is in my experience suited for excision. This is due mainly to the insidious nature of the disease, which enables it to make great headway before its presence is even suspected. I would impress upon you, therefore, the necessity for making a careful rectal examination in patients who come to you under the impression that they are merely troubled with hæmorrhoids, or who present vague symptoms of rectal discomfort.

2. Excision of the rectum should never be attempted unless the operator is quite certain that purgation of the intestinal tract has been thoroughly accomplished. Failure to observe this rule can only end in disaster and bitter disappointment.

3. Rectal excision is an operation which demands the most minute attention to aseptic details. As I have already explained one should aim at removing the diseased segment of the bowel without contaminating the large pelvic wound. Since adopting the method of operation which I have described my cases have recovered with remarkable rapidity, and the results as regards sphincteric control have in nearly all cases been most satisfactory.

4. The real key to a successful sacral or coccygeal resection of the rectum lies, I think, in opening early into the cavity of the peritoneum. This step can usually be accomplished in the way I have described; it enables one to get round the bowel quickly and with precision, and enormously facilitates the subsequent stages of the operation.

5. The retention of a ligature for at least forty-eight hours on the healthy bowel beyond the point at which it emerges from the anus, plays a most important part in promoting post-operative asepsis. This method of dealing with the bowel seems to me preferable to that of Kocher, in which the bowel is drawn down through the anus and sutured to the everted mucous membrane of the anal canal, the sutured parts being returned immediately within the anus. While readily granting that this is a great advance on some of the older methods, I cannot help regarding it as being attended by some risk, especially if one or more of the sutures should give way. The method of seeking to prevent this accident by dividing the sphincter I object to strongly, and this apparently is a detail which should not be overlooked in the procedure of Kocher.

6. I have not so far made any reference to what is known as the perineo- or sacro-abdominal method of operation for rectal cancer, as I consider it, as a rule, unnecessary when the disease lies within easy reach of the finger. This operation, I should say, finds its principal indication in cases of malignant disease in the lower part of the pelvic colon, and the neighbourhood

of the peritoneal reflection, where end-to-end junction from within the abdomen would be quite impossible. There are, however, instances in which the sacro-abdominal operation might be employed with advantage for cancer mainly confined to the rectum. If, for example, on exposing the latter from behind in the usual way, I found myself debarred from reaching the peritoneum owing to the bulk of the growth, and still more so if I found unequivocal evidence of lymphatic disease extending well up into the mesentery of the pelvic colon, I would not hesitate in having recourse to this combined method. Under such circumstances I would temporarily plug the sacral wound and place the patient in the Trendelenburg position. I would then, on opening into the abdomen, secure the pelvic colon, and deal with it and the rectum in the usual way, and at the same time remove the hæmorrhoidal lymphatics.

To the so-called perineal method of performing rectal excision I have made no allusion because I think if one excludes those cases in which the disease implicates the sphincteric zone—and certainly such in my experience are rare—perineal excision of the rectum had better be abandoned in favour of the more extensive procedure in which the coccyx, or preferably the coccyx and a small piece of the sacrum, are removed. Without the room thus provided one is necessarily hampered, working on aseptic lines is well-nigh impossible, and a good functional result, at least, as I understand it, is practically out of the question.

NOTES ON
POST-OPERATIVE PAROTITIS.

CYLLIN AS A POST-OPERATIVE ANTISEPTIC.(a)

BY

H. MACNAUGHTON JONES, M.D., F.R.C.S. I & E.

The danger of infection to injured or wounded pelvic structures after operations on the pelvic viscera, from the contiguity of these to the bowel, is well recognised. The frequency with which post-operative adhesions are found between the adjacent organs and the rectum or the cæcum, and, less frequently, the small intestine, when the abdomen has to be opened after operation, is also known. The severing of such adhesions, and stripping them off from the bowel, at times involves the denuding of the peritoneal covering and exposes raw surfaces. Though we may cover these most carefully with peritoneum, the risk of infection is increased. This risk must be intensified if there be virulent organisms present in unusual proportion in the bowel. Operations have frequently to be performed at short notice, when there has been but little time for disinfection of the bowel. There can be small doubt that every now and then instances of auto-infection occur which puzzle the surgeon and baffle the most careful aseptic methods. These are at times due to the septic influence carried from the bowel. The knowledge of the fact that the dreaded bacterium coli has the power of passing through the intestinal wall intensifies our apprehension. Hence, the great importance of keeping the intestine, especially the cæcum and rectum, as free as we can from the presence of such germs. All patients operated upon by me are previously treated by calomel and free enemata, and of late I have occasionally also used the disinfectant I am bringing before your notice to-night. I do not think we can exaggerate the importance in gynaecological operations of pre-operative and post-operative attention to the disinfection of the whole digestive tract.. Convinced that there is greater disturbance of the stomach, and that digestion is more interfered with by the administration of ether than chloroform, I have not had ether administered in any abdominal operation for some five years, and I must say that with the use of the Vernon Harcourt Inhaler, I believe the tendency to sickness and gastric disturbance has been less. In May, 1903, I read a paper before this Society on the "Importance of Attention to the Mouth and Teeth Before and After Operations on the Pelvic Viscera," which led to a considerable discussion. I then instanced a case in which the parotitis set in on the fourteenth day after operation, and in which the affection proved fatal. While noticing the various views as to the causation of the parotitis, whether toxic from the pelvic viscera through the lymph and blood channels, or, the neural theory, through a sympathetic excitation conveyed through the sympathetic system, I instanced cases in which the affection had unquestionably a dental origin, and summarised the anatomical sources of direct infection through the mouth. Last year I operated on a lady, æt. 53, for hæmorrhoids. Everything went on well until the third day after operation, when inflammation of the parotid set in, and the gland swelled rapidly, with all the usual symptoms of parotitis, including inability to open the mouth and considerable pain. On the morning of the fifth day I had two teeth in the lower jaw at the corresponding side extracted. The dentist reported that the molar and bicuspid tooth removed were both dead teeth. There was periostitis of the fangs of the molar, the alveoli were in a state of inflammation, a general condition of gingivitis being set up by the septic teeth. On the day following I made a free and deep incision through the inflamed tissues, coming down on a slough and evacuating about a teaspoonful of pus. The cavity was thoroughly cleansed out with formalin solution, a drain inserted, and the patient recovered perfectly. I refer to the case, as here again there could be no doubt that the causation of the parotitis was due to septic absorption from the teeth. The staphylococcus pyogenes aureus is the most vigorous organism found in the mouth, and for it the co-efficients of cyllin, carbolic acid, and formalin respectively and relatively are 9·37, 1·00, and 0·37. I have been using cyllin as a mouth wash after operation in the strength of 1 in 2,000, and I find this a most efficient oral disinfectant. I combine it with formo-lyptol, 25 per cent., which makes the wash pleasanter for use. The purpose, however, for which I bring this disinfectant before your notice is to advocate its employment as a pre-operative and post-operative intestinal disinfectant in gynæcological surgery. It is sufficient to give the co-efficients of cyllin, carbolic acid, and formalin, in their action on the bacterium coli, which for this organism are respectively and relatively, 10·0, 1·0, 0·3., and these conclusions arrived at by Professor Klein and Dr. Summerville, of King's College, have been confirmed by Lieutenant-Colonel Firth and Dr. Samuel Rideal. I have now been using cyllin for some nine months, on and off, in all cases in which serious bowel complications have been met in the pelvis during operation. Also in cases of appendisectomy, and not in a single case have I found it produce any unpleasant effect, nor has it been ill-borne. During that time I have had two deaths not due to any intestinal or peritoneal complication. I cannot, of course, speak definitely of its special action in any particular case, but my impression is that it is a valuable therapeutical aid in preventing intestinal sepsis and disinfection of the bowel. I have to thank Dr. Lodwidge, of Walton, for first calling my attention to the value of cyllin as a germicide. His interest was mainly centred on its action on tuberculous sputum. He brought under my notice shortly after they were carried out, the experiments of Professor Klein on the sterilisation by cyllin of tuberculous sputum. Those experiments showed that virulent tuberculous sputum was completely disinfected in twenty-four hours by a dilution of cyllin (1 in 800). The same sputum was not affected by a dilution of carbolic acid (1 in 70), the cyllin being at least eleven times more powerful.

THE Congress of Public Health has resolved to urge the Government to appoint a Royal Commission to deal with the sanatorium treatment of pulmonary tuberculosis for the poor.

(a) Read before the British Gynæcological Society, London, July 18th, 1905.

SCALP ISOLATION

AS A NEW TREATMENT FOR

SCHOOL RINGWORM. (*a*)

By DAVID WALSH, M.D.,
Senior Physician, Western Skin Hospital, London, W.

Ringworm is essentially a school disease and a disease of the great towns. Not only is it highly contagious, but, owing to the peculiar ways of children, it is extremely liable to be conveyed from one to the other. By some mysterious law of nature the playful exchange of caps seems to be a never-ending source of amusement to children. In addition to being highly contagious, ringworm is, generally speaking, a lingering and rebellious complaint. The majority of cases may be cured by skilled treatment within six to twelve months, while others take two or three years or more. In one case mentioned by Aldersmith, the disease lasted for no less than seven years. Ringworm, moreover, is often difficult to detect, and unrecognised and unsuspected cases are always found in investigating school outbreaks. It is no less difficult in many instances to say when a case is definitely cured, and many children are sent by their parents back to school with the disease in an active condition, after having undergone a short course of treatment at a special hospital.

From the foregoing facts it follows that ringworm is a serious malady, especially when we take into consideration the interruption to education that is involved under existing conditions. No responsible medical man could sanction the attendance at school of a child suffering from ringworm. As a matter of fact the disease is common among Poor Law and Council and Board Schools, whereas it is comparatively rare in the private and public schools of the wealthier classes. This shows that the prevalence of ringworm is mainly a question of environment. Indeed, were it not for the merciful dispensation of Providence which ordains that ringworm practically dies out at about fifteen years of age, the complaint would be more or less universal at all ages among the poorer classes of the United Kingdom.

In spite of the difficulties that surround the problem of prevention, there nevertheless underlies all our investigations the comforting conviction that ringworm being a preventable disease will some day be surely prevented.

One of the chief obstacles in dealing with ringworm lies in the fact that hitherto no method of rapid and certain cure has hitherto been discovered by medical science. A host of remedies have from time to time been vaunted as "certain cures" for the disease. Among these may be mentioned chrysarobin, glacial acetic acid, blistering, thymol, salt, croton oil, metallic oleates, biniodide of mercury, formalin, tincture of iodine, the X-rays, and many others. In spite of the long list of remedies no royal road to the cure of ringworm has yet been found. All the remedies mentioned will cure some cases rapidly, but none of them will cure all cases, while in a few instances all of them fail altogether. In practice remedies may be divided into those which act by virtue of their direct germicide powers and those that act indirectly by exciting a reaction in the surrounding tissues. The new method shortly to be described aims at a combination of the direct and indirect methods with a local means of isolating the actively contagious scalp.

In the Metropolitan Poor-law Schools, the ringworm children are now classified and kept apart in special schools where treatment can be carried out without interfering with education. In the County Council and elementary schools of the United Kingdom isolation of that kind would be impossible. The only alternative plan of ridding those schools of the disease under existing methods would be to exclude all affected children from attendance by skilled medical inspection. As Aldersmith points out, such exclusion wou in the majority of cases mean practically the loss of th whole school life. The prevalence of ringworm in son County Council schools must be simply appalling, we may judge from the numbers of such childre brought for treatment to special hospitals for disease of the skin. It is impossible to get exact statistic In 1894, Aldersmith and Abraham examined abou 600 children from two London Board Schools an found only 3 per cent. suffering from ringworm. Tha percentage, however, cannot be accepted as represent ing the average prevalence in such schools, for Alder smith himself between 1887 and 1896 rejected 4 per cent. of applicants to Christ's Hospital, a middle class school, on account of ringworm. Moreover, whe an outbreak occurs in a public school of the highe class more than half the scholars have been ofte attacked. Now that a medical officer has been appointed to supervise the County Council scholars exact details as to prevalence will shortly be forthcoming. Dr. Ker, however, has not held the office in question long enough to be able to furnish those particular statistics. As things stand, affected children are treated either at home by private practitioners or at hospital. In either case the parents are required to produce frequent medical certificates of exemption to the school attendance officers. The result of this pressure and of the ignorance of schoolmasters and of school attendance officers no less than of parents, is that many of the children are sent back to school in an uncured condition, where they once again become active centres of infection.

Medical authorities are agreed that every case of ringworm, however slight, should be at once isolated. Surely, in face of that opinion, it becomes the bounden duty of the London County Council and all other education authorities throughout the Kingdom not only to weed out cases of ringworm from their schools, but also to take every possible precaution to prevent affected scholars from returning.

Yet the problem of how to deal with school ringworm, although beset with difficulties, is not without a ray of hope. Although we cannot isolate school children suffering from ringworm, it is nevertheless possible to isolate their scalps. The mountain may not come to Mahomet, but Mahomet may still go to the mountain. It stands to reason that if we can encase the shaved scalp in an impervious envelope or cap we shall, for the time being, prevent the spread of infection from that particular scalp.

The method may be described in detail somewhat as follows: The scalp is first shaved, no matter whether there be one patch of ringworm or many; it is then rubbed with turpentine, washed with soap and water, and dressed thoroughly with a germicide, such as a weak solution of formalin or sulphurous acid. It is then exposed to the X-ray tube for ten minutes, and finally painted with several coats of a 10 per cent solution of salicylic acid in flexile collodion. In the next few days a fresh coat of collodion is applied, especially if there is any tendency to crack in the film or collodion-cap. If desired, the cap-film can be strengthened by a coating of rubber solution, by Unna's zinc gelatin, by fastening on a thin layer of cotton wool or by strips of rubber adhesive plaster. After a week or ten days the whole cap-film is forced up an eighth of an inch or so from the scalp by the growth of the healthy hair. The loosened film can then be gently stripped away, bearing on its under surface the firmly adherent stumps alike of diseased and of healthy hairs. In short, a wholesale depilation has taken place, especially if the X-ray dosage has been accurately administered so as to loosen the hair bulbs. The cap-film, if it cannot be stripped off without causing too much pain, may be made easier of removal by inserting a pair of curved scissors between the film and the scalp and snipping through some of the hairs. The shaggy under surface of the separated cap film is remarkable. The ringworm hairs are twisted and irregular as when they were on the scalp and some of them are often turned white, presumably by the action

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(a) Paper read in the Child Study and School Section of the London Congress of Public Health, July 21, 1905.

of the ether in the collodion. The process may be repeated as often as may be deemed necessary. In cases where large areas of scalp have been denuded in this way, the hair has later grown again vigorously, so that there need be no fear of permanent baldness.

Collodion is somewhat costly, but no doubt many cheaper substitutes, such as rubber solution, could be found.

The essential points about this new method are the general depilation of the scalp after the hair bulbs have been loosened by exposure to the X-ray tube or by the application of a mild irritant remedy. Removal is effected by means of a cap-film of some adhesive substance, whereby isolation of the infectious scalp is at the same time effected. Various experiments show that it will be easy to contrive cheap and efficient substitutes for the collodion film. The X-ray exposure, if that method be used, should not be more than ten minutes' duration. Not more than two or three applications are needed, with intervals of ten days between each.

The advantages of the combined cap-film method of treating ringworm are the following:—

1. Infection of other children is prevented by isolation of the individual scalp.
2. Cure is hastened by the depilation alike of diseased and of healthy hairs.
3. The depilation of diseased stumps is effected by an extremely slow but powerful traction upon a bulb loosened by the application of the X-rays, or by some mild local irritant remedy.
4. The method differs from all hitherto devised inasmuch as it combines direct and indirect curative measures with local isolation.
5. The X-rays, if wished, can be applied through the cap-film.
6. The children affected with ringworm can attend school if their scalps be thus local isolated.
7. Treatment need not be applied oftener than once every week or ten days.
8. In large towns affected children could be brought to a central station for treatment by an expert.

In conclusion, it may be remarked that under this or any other plan success in stamping out school ringworm can be attained only by the help of skilled and systematic medical inspection. Without such aid it would be impossible either to detect cases, to treat them properly, or to say when they are cured. The special cap-film treatment would have to be carried out, say, in London at a central station under the control of a medical man experienced in ringworm cases. What is claimed for this method is that it materially shortens the period of treatment, while it prevents the spread of infection and enables the affected child to attend school. The London County Council will doubtless rise to the occasion and before long organise a method of ridding their schools of ringworm. It may safely be predicted that sooner or later public opinion will insist upon the adequate and scientific treatment of this preventable evil that now scourges the juvenile population of the United Knigdom.

A CASE OF ENDOTHELIOMA OF THE UTERUS. (a)

By R. CHARLES B. MAUNSELL, M.B., F.R.C.S.I.,

Member of the Council of the Royal College of Surgeons, Ireland; Surgeon to Mercer's Hospital, Dublin.

The case I am about to describe to you is one of a class which appears to be of great rarity. Its chief interest is pathological, but I am not in a position to state new facts or theories, nor to discuss the case from its more scientific aspect.

This communication is intended to record the clinical symptoms and operative treatment, together with a short histological report, kindly made for me by Dr. H. C. Earl.

B. D., æt. 40, married, was sent to me on October 10th, 1903, by Dr. J. G. Flannery. She complained of progressive weakness, swelling of the lower part of the abdomen and discharge of very fœtid pus from a sinus which opened about an inch below the umbilicus. The family and previous personal history contained nothing having any bearing upon her present condition, except the following few statements with regard to menstruation and pregnancies. Menstruation commenced at the age of fifteen years and continued regularly, except for physiological stoppages until December, 1902. Five healthy children had been born, the eldest of whom was fourteen years of age and the youngest three years. The children were breast-fed for a period of twelve months.

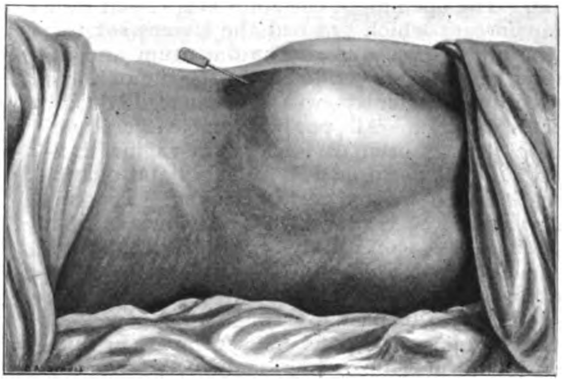

FIG. I.

In December, 1902, the menses did not appear, and the patient considered that she was pregnant, although there was no morning sickness, as in her previous pregnancies.

Towards the end of January, 1903, a bluish-red swelling developed below the umbilicus. This swelling was poulticed, and it burst during the early portion of March. In August, 1903, the menses appeared for five days, but since that date they have been absent.

The patient was a rather spare, anæmic woman, having the appearance of one suffering from prolonged suppuration rather than from malignant growth. Her temperature was hectic; urine of sp. gr. 1020, acid, no albumen. The lower portion of the abdomen was distinctly prominent (see Fig. 1), and a sinus, discharging fœtid gas and pus, was present about an inch below the umbilicus. The skin around the opening of the sinus was excoriated by the discharge. Palpation of the abdomen revealed an oval, firm, non-fluctuating mass which reached from the pelvis to the umbilicus, filled the right iliac fossa and extended slightly to the left of the middle line. Over this mass the percussion note was dull.

Upon vaginal examination the uterus and left appendages appeared normal; the right tube and ovary could not be palpated, and the tumour was either continuous with or adherent to the right cornu of the uterus. By means of a sound the uterine cavity was found to be of normal dimensions, whilst synchronous movement of the tumour and the uterus could be demonstrated. The sound was then withdrawn and passed into the sinus in the abdominal wall. It passed for a distance of six inches, could be freely rotated in all directions within the tumour, and its point could be distinctly felt through the right fornix of the vagina, with apparently very little tissue intervening between it and the examining finger.

(a) Read before the British Gynæcological Society, July 13th, 1905.

The diagnosis lay between a sloughing myoma, suppurating dermoid or suppuration from the sac of an extra-uterine pregnancy. The diagnosis made was that of sloughing myoma.

Operation.—An elliptical incision was made, including the sinus and the unhealthy skin around it, the lower portion of the ellipse being prolonged towards the pubis as an ordinary median incision. The opening of the sinus was closed by a clamp forceps which grasped the tissues set free by the above procedure. The omentum and intestines were densely adherent to the tumour, and considerable difficulty was experienced during their separation. All parietal and visceral adhesions having been divided supra-vaginal hysterectomy was performed, both tubes and ovaries being included in the parts removed. The cervical stump was then drawn up by means of a vulsellum, and completely excised. The lower abdomen and pelvis were flushed with saline solution, which was drained away by a large glass tube, temporarily passed through the open vault of the vagina. The pelvis was completely filled with iodoform gauze, one end of which was passed into the vagina and the other end left protruding from the abdominal incision. Through-and-through sutures of silkworm gut were inserted, but not tied. The lavage and drainage were employed owing to the septic condition of the skin of the abdomen, and also as some pus had escaped into the pelvis during the tedious separation of adhesions.

Subsequent to operation the case ran an uneventful course, the gauze being removed and sutures tied on the fifth day. The patient returned to her home three and a half weeks after the operation. I have heard recently from Dr. Flannery that there has been no recurrence of the growth and that the patient follows her usual occupation.

Upon macroscopic examination of the parts removed, the cervix, body of uterus, and the left appendages appear normal. The right half of the fundus and right cornu of the uterus are continuous with an almost globular tumour, which measures 38 cm. in its greatest vertical circumference, and 33 cm. in its greatest transverse circumference (see Fig. II.). The right tube springs from the right side of the tumour at its middle, is of normal length, when compared with its fellow, and its fimbriæ abut against the right ovary, which is adherent to the lower pole of the tumour, but is otherwise normal. The right round ligament springs from the tumour 5 cm. below the apparent origin of the tube.

The surface of the tumour is covered with shreds of tissue, which remain after the separation of adhesions during the operation. At the upper pole of the tumour and slightly to its left side is a sinus, together with an ellipse of abdominal wall and a piece of adherent omentum.

When the uterus is opened its cavity is found to be normal, and does not communicate in any way with the tumour. Upon opening the tumour it is found to be enclosed in a definite capsule of uterine tissue varying in thickness from a centimetre at the lower pole to a millimetre at the upper pole, except in the vicinity of the sinus where the capsule has been destroyed. Careful examination by means of sections discloses the fact that the right cornu of the uterus does not communicate with the right Fallopian tube.

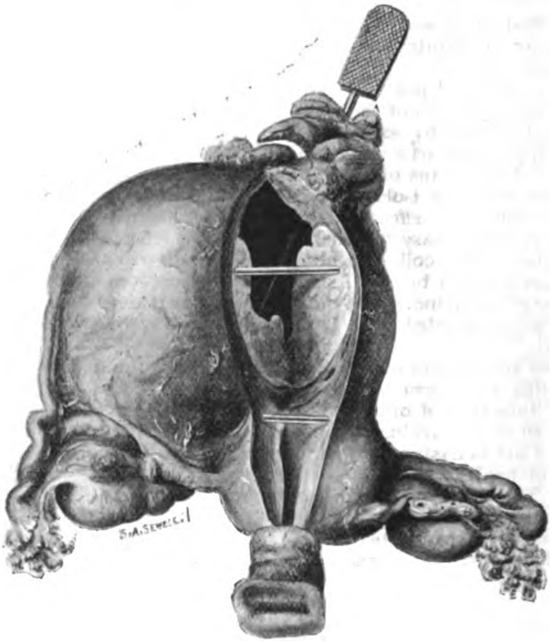

FIG. II.

Inside the capsule of the tumour at its basal portion there is an irregular firm mass of growth rather like a myoma; the rest of the capsule is lined with a thin layer of the same growth. Dr. H. C. Earl kindly made sections of the uterus, tube, adhesions and tumour, but the tumour alone shows anything of pathological importance. The accompanying micro-photographs have been made by Dr. J. T. Wigham, of the School of Pathology, T.C.D.

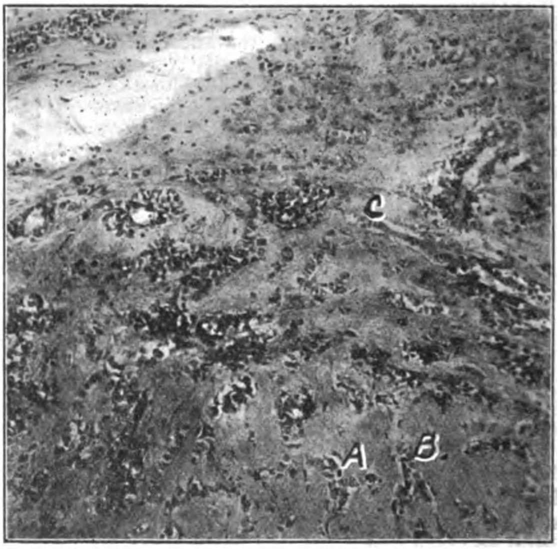

FIG. III.

Dr. **Earl**'s report: "The tumour consists of a stroma of very dense connective tissue, in which are alveoli of varying size, but generally small. These alveoli contain masses of small cells with round nuclei and a thin layer of protoplasm. The tumour has the general appearance of a carcinoma, though the cells are smaller than are usual in carcinomata. There are many parts of the sections from which no other histological diagnosis could be made than that of carcinoma. On further careful examination several appearances are seen which make it evident the cells filling the alveoli are derived from the endothelium of the vessels. It is possible to trace a connection between some of the alveoli filled with cells and normal small vessels, and, as is well seen at A and B (see Fig. III.), a connection can be traced between the normal endothelium of vessels and the cells that fill the alveoli. In some of the vessels the endothelium has become cubical on part of the vessel, as at C (in Fig. III.). It is also worthy of note that even in alveoli in which the cells, as is generally the case, cannot be traced to the endothelium of vessels, the outer cells of each mass are cubical and form a fairly definite lining to the alveoli." The diagnosis is therefore endothelioma of the fundus of the uterus.

Clinical Records.

LIVERPOOL NORTHERN HOSPITAL.

Two Cases of Excision of Gasserian Ganglion for Neuralgia.

Under the care of **Damer Harrisson**, F.R.C.S.E.,
Surgeon to the Liverpool Northern Hospital, &c.

Case I.—J. G., æt. 45, labourer. Was admitted into the Liverpool Northern Hospital, March, 1893, having suffered from paroxysmal neuralgia on the right side for five years. The attacks had been of dreadful severity, recurring sometimes in the morning, sometimes in the evening, with varying periods of entire relief. At this time (1893) the pain was in the inferior dental and infra-orbital nerves, and the first operation consisted in opening the inferior dental canal and excising ¾ inch of the nerve, and stretching the infra-orbital nerve at its exit from the infra-orbital foramen. This operation was followed by immunity from pain for ten months.

The second operation was in November, 1894, and in this case all the steps for removal of the Gasserian ganglion by the pterygoid route were followed until the inferior division of the fifth nerve was exposed at its exit from the foramen ovale; it was there seized with forceps and torn from its connection with the ganglion. The middle division of the fifth was dealt with in the same way by means of a hook in the spheno-maxillary fissure. After this second operation there was immunity for nine months.

The last operation (July 10th, 1896) was removal of the Gasserian ganglion by Mr. Rose's method, and was difficult to perform in consequence of the guides to the foramen ovale having been removed at the previous operation. There has been no recurrence of pain since the ganglion was excised, now eight years ago.

Case II.—J. B., æt. 40. Was admitted into the Northern Hospital in December, 1896, having suffered from increasingly painful attacks of neuralgia during the previous three years. The Gasserian ganglion was excised, with complete immunity from pain up to this time, seven years and eight months from the date of the operation.

The operation by the pterygoid route is dangerous and difficult, and certain objections may be urged to this route when compared with the temporal route which has been adopted in recent years. The wound leaves a disfiguring scar upon the face; there may be necrosis of the zygoma, and the coronoid process may be lost. There is often severe bleeding from the pterygoid plexus of veins and from the internal maxillary artery. There may be difficulty in finding the foramen ovale, and danger of sepsis from accidental opening of the Eustachian tube.

These cases are of special interest from the long immunity from pain which I am able to report in each case—a longer period without recurrence has so far not been reported.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting held Thursday, July 13th, 1905.

Dr. **William Alexander**, President, in the Chair.

Dr. **Charles Maunsell** read the particulars of an interesting case of

ENDOTHELIOMA UTERI,

illustrated by drawings and micro-photographs, which will be found under the heading of "Original Communications," page 83.

In the discussion that followed—

Mrs. **Scharlieb**, M.D., stated that she recently read notes of a case of endothelioma of the uterus, which was singularly like the one just described by Dr. Maunsell, both in its macroscopical and its microscopical characters. There was a large formation of new vessels, many new lymphatics, many of which were filled with cells. She would have much pleasure in showing the specimen and the slides on a future occasion.

Dr. **Macnaughton-Jones** said that the Society was indebted to Dr. Maunsell for bringing forward this case. So far as he knew, no similar one had been as yet recorded. Endothelioma of the uterus was extremely rare. This was not the case with regard to the ovary, for Lange had collected, up to 1903, over forty cases of the latter. This was accounted for by the difference in the histology of the two organs. It would appear that in Dr. Maunsell's case the endothelial growth commenced not from the outer sheath, but from the inner or endothelial lining of the vessels. Of the two chief sources of origin, lymphatic and vascular, his case appeared to be of the latter.

Dr. **Smallwood Savage** proposed that the specimen should be referred to the Pathological Committee of the Society.

Dr. **Macan** proposed that Dr. Maunsell's name be added to the Committee, and seconded Dr. Savage's proposition.

Mr. **Bowreman Jessett** asked what were the contents of the tumour, and the patient's age?

Dr. **Bell** asked whether there were any early uterine symptoms before those narrated manifested themselves? Was there any discharge from the uterus, or had that organ been interfered with previously by curettes or otherwise before the patient came under Dr. Maunsell's care?

Dr. **Maunsell**, in reply, said he had to thank Mrs. Scharlieb and the others who had kindly spoken on his paper. Under the term endotheliomatous endometritis conditions were described, but he could not find a description of endothelioma occurring in the substance of the uterus, as that tumour appeared to do. He would be glad to have the tumour submitted to the Pathological Committee. In reply to Mr. Jessett, the cyst had been discharging for nine months through the sinus in the abdominal wall, and contained only pus and degenerated cells. Mr. Bell asked whether curetting had been done. There had not been any treatment at all beyond poulticing the swelling in the abdominal wall. She came to the hospital, from the West of Ireland, where she had no gynæcological treatment. The patient had poulticed the swelling herself until it burst.

Dr. **Maunsell** also read some notes on an improved method of

VENTRO-SUSPENSION OF THE UTERUS,

which we hope to publish next week with illustrations.

Dr. H. MACNAUGHTON-JONES: read a short paper on POST-OPERATIVE PAROTITIS, WITH NOTES ON CYLLIN AS A POST-OPERATIVE ANTISEPTIC which will be found on page 81.

In the discussion which followed.

Mr. W. CHARROTT LODWIDGE said he was responsible for the preparation which Dr. Macnaughton-Jones had just brought forward, because he first practically introduced it to the profession at large. When he first came to take up the substance as an intestinal antiseptic he helped Dr. Bousfield to discover what action it exerted upon the secretion of the bowels, and also on the bacteria of the bowel, and whether it had any injurious effect on the body. Thirty-six minims a day for eight days were given to a patient in the form of 3 min. palatinoids, and the fæces examined every day. At the end of eight days the number of the bacillus coli in the intestine was reduced by 97·5 per cent. The substance had produced no toxic effects whatever. He had used it in the case of young children, even as young as fifteen months of age, 6 min. a day, and there had been no trouble whatever. It was an oxidised hydrocarbon, having a diphenyl nucleus in place of the single phenyl found in carbolic acid and its homologues, Cyllin had antiseptic properties, which varied according to the bacterium for which it was used. For instance, it was thirty-four times stronger than carbolic acid for B. pestis, it was eleven times as strong for tubercle, and nine times as strong for the staphylococcus pyogenes aureus. Dr. Klein also suggested to him that it had a specific action on the white corpuscles of the blood. It not only destroyed the tubercle bacilli, but it induced an increased phagocytosis.

Dr. ROUTH considered that much depended on the condition of the mouth in the treatment of a great number of diseases. He had made it a rule in many cases, whatever the disease was, when the man or woman was losing his or her appetite and flesh, to turn his attention to the mouth, and almost always found the breath foul. Frequently after giving five drops of dilute carbolic acid all the symptoms disappeared in a day. Cyllin, he believed, was one of the best medicines of the same kind, because it was comparatively harmless, and almost any reasonable quantity of it diluted could be taken without injury. Certainly it was more powerful than carbolic acid, was much less dangerous, and as such it was a remedy which should be used in all cases for vaginal injections.

Dr. MACNAUGHTON-JONES, in reply, said that one of the most interesting matters connected with operative gynæcology was the occurrence of parotitis after such operations as ovariotomy, and similar pelvic operations.

[NOTE.—The remaining papers and discussion at this meeting will be given in our next.]

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 23rd, 1905.

A NEW TREATMENT OF WHOOPING COUGH.

NUMBERLESS are the drugs given for pertussis. Amongst the new agents there appears to be one however, which may claim a certain efficacy—gomenol. According to Prof. Ausset, of Lille, this drug has succeeded in his hands in several cases of the most exaggerated type and where other agents had failed.

A child of 7 years of age had had the whooping cough already one month. A mixture containing grindelia, belladonna, valerian, produced no relief. Vomiting persisted in spite of large doses of antipyrine. The patient had from 30 to 40 attacks daily. It was at this period that injections of a solution of gomenol and oil (20 per cent.) were begun. The first day 10 cubic centimetres (2½ drachms) were injected, but the condition remained the same. On the third day the seizures were diminished by one third and the vomiting had ceased. Improvement from that time was astonishingly rapid, for a week later the child had only five attacks, and twelve days after the first injection they had disappeared. The patient coughed a little still, and the injections were replaced by fumigations of gomenol and a fortnight subsequently the patient had completely recovered.

Another case was that of a child of 5. The family refused at first the injections and the child was given a mixture of valerian, belladonna and antipyrine without result. M. Ausset having warned the parents of the danger to the patient of whooping cough at that age, was authorised to practise the injections. He injected 5 cubic centimetres daily (1 drachm) of the 20 per cent. solution and at the end of ten days the seizures had fallen from 23 to 4 in the 24 hours. At this period the injections were suppressed and replaced by syrup of gomenol.

TREATMENT OF BOILS AND ANTHRAX.

The treatment of boils and anthrax is general and local. The general treatment is that of the cause, uric diathesis glycosuria albuminuria. Even when no special diathesis can be incriminated certain hygienic precautions, says Prof. Reclus, are necessary,—baths, frictions with a hair glove followed by spirit of lavender, Internally beer yeast can be given with advantage to the digestive tract.

The local treatment is very simple. Pulverisations of a weak solution of phenic acid (1-100), lasting half an hour and renewed four or five times in the twenty-four hours. After each seance the antiseptic ointment, already mentioned in this journal, is applied.

As to the history, Prof. Reclus uses it rarely and only in one of three conditions. Where the pain is excessive when the tumour continues to extend in spite of the spray and where the boil is seated in dangerous regions, as the face or the upper lip, where meningo-cerebral, complications might be feared.

When an operation is indicated, a solution of storaine in the case of boils, may be injected as a local anæsthetic. The needle should be inserted outside the inflamed region and pushed under the tumour, which becomes white; at that moment it can be opened largely without the slightest suffering and the pulverisations continued with the antiseptic dressing.

In cases of anthrax, which do not yield to the spray and the antiseptic ointment the thermo-cautery should be used in the place of the knife, and the patient put under chloroform. But, adds M. Reclus, cases of surgical interference are happily rare, for the great majority of cases, whether of boils or anthrax, yield to the simpler treatment above detailed.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 23rd, 1905.

AT the Society for Innere Medizin, Hr. Hans Kohn showed preparation from a case of

GANGRENE OF THE LUNGS,

excited by a foreign body in the bronchus. The foreign body was a chicken bone that got into the bronchus in August last. The first symptoms were spasmodic cough, with purulent, and finally fœtid, expectoration. The diagnosis was not clear at the earlier periods. The history was doubtful, no bronchoscopic examination was made, and when at last a diagnosis was made by aid of the bronchoscope, the gangrene had become extensive and the patient's condition had got so bad that there was no possibility of avoiding a fatal ending to the illness. The case was a warning that when there was even a remote suspicion of the presence of a foreign body in a bronchus, bronchoscopy ought to be resorted to.

Hr. A. Fraenkel observed that since the introduction of the bronchoscope admission of a foreign body into a bronchus ought not to be dangerous so long as proceedings were taken sufficiently early. The case before them came under his observation only in February last; there was then infiltration of the whole of the lower lobe of the right lung. The patient stated that he believed he had got a piece of bone in his windpipe in August last, but his statement was not at all a decided one. He proposed the bronchoscope, but the use of the instrument was declined. The use of it, however, at that stage, and the discovery of the foreign body would scarcely have been helpful, as the bone had been there months already, and its extraction would not have averted the unfortunate termination. Moreover, the diagnosis appeared very uncertain for the following reasons:—

(1) There was already a rectal fistula that raised suspicion of tuberculosis; (2) tubercle bacilli were found in the expectoration, so it really appeared to be a case of gangrene of the lungs caused by the tuberculosis and the expectoration was putrid even then.

Hr. Edm. Meyer had seen the patient for the first time only two days before. He was then worn down and had fever, and was sent to him for bronchoscopy. The bronchoscope was introduced under cocaine, and was successful in showing a foreign body embedded in soft mucus, and lying in a bronchus of the third degree. On account of the distressful condition of the patient, however, it was not extracted. By means of the bronchoscope one could make quite certain that the case was not one of single large abscess, but that there were a large number of smaller ones scattered about so that there was no indication for surgical interference. Probably a timely use of bronchoscopy would have led to a favourable result. As it was not a dangerous procedure, it might be made use of on suspicion only.

Hr. Heubner observed that one of the assistants in his Klinik had succeeded in extracting a foreign body from the bronchus of a child after bronchoscopy months after it had been swallowed, and after it had set up putrid bronchitis, and that the child had made a perfect recovery.

At the Surgical Congress, Hr. Hackenbruch spoke on

The Treatment of Infantile Paralysis by Nerve Grafting.

He showed a child, æt. 13, whom a year and a half ago he had treated by implantation of nerve. There was paralysis of the peronei and extensor muscles. The tibial and peroneal nerves were exposed and a long strip from the tibial was introduced and fixed into the sheath of the peroneal. Recovery was uninterrupted. After four and a half to five months distinct movements of abduction could be seen; the muscle was not movable electrically. Now, after a year and a half, the function was perfect, the muscle responding to both galvanic and faradaic currents.

Hr. Rehn spoke on

Tumours of the Bladder among Aniline Workers.

He had already reported on twenty-three cases of such tumours at the last Congress. He now showed a preparation from a man, æt. 50, who had worked at aniline works for eighteen years. He had bladder troubles, and had the high operation performed for tumour of the bladder a year ago. Recovery was slow, but in the end the patient was discharged free from trouble. In January of the present year, he got hæmaturia, bladder disturbance, and in February retention of urine. There was recurrence of the disease, and an operation was again performed which was very difficult. The high operation was again done, and the bladder was also entered from the perinæum. The patient died six weeks afterwards. The autopsy showed carcinoma of the right kidney and of the right ureter. The preparation showed that the cancer of the kidney was the primary lesion, that the disease had not reached the ureter along the lymph track. The symptoms due to the bladder disease had therefore masked those of the kidney mischief.

Austria.

[From our own Correspondent.]

Vienna, July 23rd, 1905.

Congenital Defect in Septum Ventriculorum.

At the Gesellschaft für Innere Medizin, Drey showed a child, æt. 3½, who was cyanotic when nine months old, and then observed to be rachitic. In its history it had chicken-pox and several times inflammation of the lungs.

About the beginning of February the following conditions are recorded on its reception into hospital:—An imperfectly nourished child, with a rachitic thorax. There is no cyanosis, nor dyspnœa to be observed, but a distinct tendency to drumstick fingers was present. The left side of the chest was quite vaulted, but no "fremissement" nor pulsatio epigastrica.

Percussion gave dulness below the third rib extending to the middle of the sternum towards the right, and the anterior axillary line to the left. The apex beat was in the axillary line with a loud blowing systolic murmur, loudest over sternum and third left intercostal space, where the sound was harsh and grating; the second sound was loud and strong on closing, which could be heard along the pulmonary artery. The pulse was small and regular; no rising of the vessels in the neck, and no pulsation could be detected in the jugular vein.

The Röntgen rays only tended to confirm the clinical examination, particularly the cardiac area of dulness. It may be mentioned that a few glands about the size of peas were detected over both clavicles, as well as both axillæ, with a few large rales in the bronchi.

With these complex phenomena he was inclined to reserve judgment, but considered it one of septal defect with insufficiency of the mitral valves.

Hochsinger said that he had seen this little patient in its fifth month, and thought there was no mistake about the diagnosis of a serious defect in the wall of the ventricle, but there certainly was a little mystery about the disappearance of the cyanosis on admission to hospital. He thought this might be explained by the higher pressure in the left ventricle, even with a defective septum, where the blood would be pressed from left towards the right side and not *vice versa*, as occurred when the patient was younger, and when the cyanosis was present.

Adenoid Vegetation.

Spieler showed four patients from the Ambulatorium of the Carolinen Hospital, whose ages ranged from eight years to thirteen years, with bilateral exophthalmia associated with vegetation on the tonsils. He contended that this combination was more common than Holz would accept. Within a very short period he had met with a number of these cases, but would not venture to theorise on the cause of the exophthalmia, although it subsided after removal of the adenoid from the throat. One of the cases presented had recently been curetted and the testimony of the mother and friends was that the ophthalmia was now much less. It would seem from this that some connection exists in the etiology of the disease, probably due to the adenoid first causing a hyperplasia in the throat which may act on the lymphatic circulation and subsequently cause a congestion of the retrobulbar lymphatic that may lead to the exophthalmia. This is only presumption, but such an anatomical connection may be established.

Among his cases were a few "tower crania," which show deformity in this direction, but such skulls usually have no influence on the production of exophthalmia.

Rhino cleroma.

At the Gesellschaft, Freund showed a case of a man who came to him on April 19th, with an intractable rhinoscleroma. He immediately commenced the Röntgen rays with six minutes' exposure at a time.

Making no improvement, the treatment was stopped and recommenced after a long pause. This was repeated three times so that the whole treatment of twenty-three exposures may be divided up into four series, which resulted in an increase of the pigment, but no visible change in the tissue.

The rays were finally given up as inoperative, but, strange to relate, shortly after stopping the rays the nose began to soften and the infiltration to disappear.

The upper lip is still a little thickened, but the face and nasal orifices are quite free, permitting the patient to breathe freely, which he could not do before.

Relation of Cardiac Volume to Pulse.

Heitler reminded the members of his experiments on animals in 1889 to prove that the heart was altered in volume immediately the pulse was altered and *vice versa*. Shortly after these experiments his attention was directed to arhythmia, which further proved his experiments on dogs to be correct.

His latest experiments were on the human heart by acting on the pulse through continued pressure over the region of the liver or upper ribs of the chest. This mechanical operation so acts on the pulse that its effects can readily be observed on the heart. This enlargement of the heart when the pulse is reduced has been verified by the Röntgen rays as well as by percussion, and is now proved to be an indisputable fact which ought to enter into our calculation in morbid anatomy.

The exact measurements of the shadow with 60 centimetres of focal distance varied between 0·5 of a centimetre to 1 centimetre; one of his measurements ceeded 2·7 centimetres. The increase of breadth is more frequently on the left side than the right, and is as often upwards as downwards.

Hungary.

FROM OUR OWN CORRESPONDENT.]

Budapest, July 23rd 1905.

At the last meeting of the Hungarian Gynæcological Society, Dr. Tuszkai Odön read a paper on

Hyperæmesis Gravidarum—a Gastro-Intestinal Auto-Intoxication.

In 1897 Dirmoser first 'enunciated' his theory that hyperæmesis gravidarum is an auto-intoxication due to the absorption of putrefactive products of albumin, such as indol and skatol, from the gastro-intestinal tract. It has received support from the work of Albu, Kraus, Nothnagel, Taksch and others.

From analyses of the urine in thirty-six severe cases up to 1904 it was found that: (1) the excretion of urobilin was abundant in all; (2) blood colouring matter was present in four cases; (3) albumen was present in small amount in all, and often varied with the severity of the attack; (4) acetone was found four times; (5) peptone was found thrice abundantly, once a trace only; (6) oxalic acid was usually increased; (7) indoxyl and skatoxyl were almost always increased; (8) urinary sediment was always abundant, it thrice contained hyaline and granular casts, and often blood corpuscles, fatty epithelium, and numerous crystals of triple phosphates, sodium urate and calcium oxalate. Dr. Tuszkai concludes (1) that the products of metabolism, normally excreted such as indol, skatol, and ethyl-sulphates, are found in increased amount in these cases; (2) that abnormal constituents, namely, albumen, urobilin, acetone, and peptone occur in the urine; (3) that acute nephritis may occur. A similar condition of the urine and kidneys is found in many acute infectious diseases, such as the diarrhœas of children, Asiatic cholera, ileus, &c., and are due to the stimulation of the kidneys by poisonous products absorbed from the bowel.

Only a few necropsies are recorded. There is usually atony of the intestinal tract, and slowly swelling and fatty degeneration of the liver and kidneys. Should this auto-intoxication theory be correct, intestinal disinfection is indicated.

Intractable Vomiting of Pregnancy.

Dr. Révész Vilmos said that the gravity of the vomiting does not altogether lie in its intensity or its frequency, for pregnant women often vomit after each meal, apparently all the food, without serious impairment of nutrition and with little or no loss of weight. On the other hand, in intractable vomiting not only is the digestive function perverted, but nutrition is very rapidly and profoundly altered; the complexion becomes waxy, the skin dry and scaly, and the epidermis cracks. In primiparæ intractable vomiting is more common in the second and third months, in multiparæ in the fourth. In the former the symptoms progress more rapidly than in the latter; not only does the vomiting immediately follow the ingestion of a spoonful of fluid, but there is a constant sensation of nausea, and continual futile and extremely painful attempts at vomiting are made. The writer recognises as causes two conditions: hysteria and auto-intoxication. Treatment differs accordingly. Either may be fatal.

What signs show the necessity of inducing abortion? Oliguria and progressive and continued loss of weight are of the greatest importance. If, in spite of treatment malnutrition is rapid and continued, the question must be raised. Expulsion of the ovum may take from one to ten days, but its death alone leads, if not to cessation, to diminution of the vomiting. In one case the patient was able to retain a glass of milk six hours after the introduction of a sound, though the ovum was not expelled. This fact shows the value of dilating the cervix, but in a primipara digital dilatation in the second or third month is impossible; then laminaria should be used.

Operating Theatres.

ROYAL FREE HOSPITAL.

Operation for Removal of a Thyroid Adenoma.—Mr. T. P. Legg operated on a woman, æt. 49, who for the last two or three years had noticed a swelling in the lower part of the left side of the neck. The swelling had slowly increased in size and was now as big as a tangerine orange; it had caused some shortness of breath and a little discomfort on swallowing. The swelling was situated in the left lobe of the thyroid; it moved up and down freely on swallowing; it was globular in shape, very elastic and smooth on its surface. The trachea was pushed over a little to the right of the neck. Examination of the larynx showed that both cords moved freely; there was very slight enlargement of the right lobe of the thyroid. A transverse incision two and a half inches long was made over the lower part of the swelling. The deep cervical fascia and the platysma having been divided, the supra-hyoid muscles were separated from one another in a vertical direction and held apart by retractors; the tumour in the thyroid was then exposed and was found to be covered by a thin layer of thyroid gland tissue; this was carefully divided till the tumour itself was reached. A thyroid scoop was next passed in between the capsule and the tumour, which last was then readily enucleated except where the vessels entered it on its deep aspect; these were clamped before being divided, care being taken to keep as close to the tumour as possible. The vessels were then ligatured and the cavity in the gland was sewn up by a couple of purse-string sutures. The muscles were then replaced, the cut edges of the platysma united, and the skin incision closed by a continuous silkworm gut suture. Examination of the tumour showed it was a typical adenoma of the thyroid; it was solid throughout and composed of ordinary gland tissue. At one part there was a small mass of calcareous material which Mr. Legg said was not uncommonly found in old-standing goitres, especially in elderly people. He pointed out also that there were two chief varieties of innocent thyroid tumours—the first, in which the whole gland becomes enlarged, this is called a parenchymatous goitre; and the second, in which definitely enucleable tumours (adenomata) are formed. The present case, he said, was a good example of the latter variety, and the importance of clearly distinguishing these two forms arises from the fact that the operative treatment of the two varieties is different. In the parenchymatous goitres extirpation of one lobe after ligature of the vessels is required; in the case of adenomata enucleation, usually a much less serious proceeding, is the treatment. Mr. Legg remarked that the diagnosis could generally be made by noticing the shape of the tumour, which is globular in adenomata, as well as by the trachea being displaced to the opposite side by the growth; it is not so important, he thought, to diagnose cysts in the thyroid tumours, because cysts are very often due to degenerations in adenomata, as it is to distinguish parenchymatous from adenomatous goitres because cystic adenomata are treated like the solid adenomata. As regards the operation itself, he said that the transverse incision is always to be preferred, as it leaves much less scarring. Two other points in the operation, he remarked, are of importance—first, to recognise and divide the layer of thyroid tissue overlying the tumour, and to make certain, therefore, that one has got into the layer of suppuration between the tumour and its capsule; if this layer is clearly recognised the tumour shells out without any difficulty. The other point is the hæmorrhage, and as this is usually venous and the veins are often very big, unless obvious veins are avoided the amount of blood lost may be very great. It is, however, generally at the last step of the enucleation, he pointed out, that hæmorrhage takes place, and it can generally be controlled temporarily by plugging the cavity and subsequently tying the vessels. It is a good plan, too, he thought, before the incision is sewn up, to allow the patient to come round partially from the anæsthetic; the straining thereby induced will often cause a vessel to bleed freely which had before been collapsed. A minor point, he considered, is to sew up the infra-hyoid muscles if they have been divided, and to unite by three or four stitches the cut edges of the platysma. This latter step brings together the margins of the skin incision and enables the surgeon to remove the skin stitches on the fourth or fifth day without there being any risk of the wound opening up. In some cases where the cavity left is large, it is advisable, he thought, to put in a drainage tube for twenty-four hours. The indications for removal of thyroid adenomata, Mr. Legg said, were, first and foremost, dyspnœa; sometimes small adenomata, especially when situated low down, will give rise to considerable dyspnœa. Another important indication is displacement of the trachea, and a third indication increase in size of the tumour, especially rapid increase in size, which suggests cystic degeneration with possibly hæmorrhage into the cyst. In elderly patients the possibility of the occurrence of malignant disease should be borne in mind in thyroid tumours, which rapidly begin to grow.

Seven days after operation the patient left the hospital perfectly well. The stitches were removed on the fourth day.

THE report of the National Society for the Employment of Epileptics, which was adopted at the twelfth annual meeting of the Governors, shows that at the end of the year 1904 the accommodation at the Colony of Chalfont had been raised to 198 beds, distributed in the various houses or homes.

THE Lord Mayor has received a cheque from the Chief Rabbi for £1,161 19s. 7d., being the amount collected in the various synagogues of London, in addition to the collections already received from the West End Synagogue (£269) and the Spanish and Portuguese Synagogue (£180). The total of the Hospital Sunday Fund is now nearly £60,000, to which Mr. George Herring will add about £12,000.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 26, 1905.

THE INFANTILE MORTALITY.

THERE is no greater blot upon our boasted modern civilisation than the excessive infantile mortality that year after year is recorded by the Registrar-General of the United Kingdom. Among a certain class of popular writers the subject is wrought up with lurid extravagance of literary treatment, but it may be doubted whether they do more than justice to the case. What words can describe adequately the appalling waste of infantile life that acts as a constant drain upon the resources of the nation? Some persons argue that intellectual methods should be exercised to curtail the production of children, while others condemn with the utmost indignation any measures that check the natural growth of population. But whatever view we may take as to the moral issues involved in the procreation of children there can be none whatever as to the necessity of putting them under favourable conditions of environment, so as to secure a maximum survival of the infantile population. The question of the excessively high infant mortality rate and the means of remedying it were ably discussed in a paper read last week by Dr. George Carpenter at the London Congress of the Institute of Public Health. The Registrar-General 's Returns for 1904 show that the average death-rate for the 76 great towns of England and Wales was 17.2 per 1,000 living, while the rate for infants in the first year of life was 160 per 1,000 births. In 142 other towns the infantile rate was 154 per 1,000, and for rural England and Wales 125 per 1,000. Certain other large towns showed a still higher rate. Thus, Birmingham had 197; Liverpool, 196; Stockport, 203; Hanley, 212; Preston, 218; and Burnley, 229. In London the highest borough rate was Bermondsey with 172, and the lowest Marylebone with 94. The infantile mortality rate in various wards of Birmingham has been shown to be no less than 331 for St. Mary's and 263 for St. Bartholomew's. These and other startling statistics that might be quoted demonstrate a position of affairs with regard to the infantile mortality rate that may be regarded as a standing menace to the future prosperity of the country. One of the most disquieting features of the situation is that the waste of life is due to a class mortality, that is to say, it is practically confined to artisans and poor classes and does not exist to any extent in the middle and upper classes. In view of the diminishing birth-rate the more or less stationary figures of the total population assume a position of extreme importance. Most medical men will agree with Dr. Carpenter's proposition that improper feeding is the main factor in the excessive infantile mortality. That statement becomes practically self-evident in the light of the further information that three-fourths of the deaths of children under twelve months of age occur among those who are bottle fed. Most medical men, also, will agree with the author's contention that the remedy for the present disastrous state of matters must be sought in the provision of a sufficient supply of pure cow's milk to the poorer classes of the community. The suggestion of cow's milk is, of course, intended only for children whose mothers for some reason or other are unable to feed them from the breast, as intended by all-wise and unerring nature. In fact, Dr. Carpenter comes round to the necessity of a municipal supply of sterilised milk, to be supplied on easy terms to the poorer population. As the same time he advocates a general stiffening of the regulations under which milk is produced and distributed. It is not within the province of the present remarks to analyse the article above quoted. Those who are interested in the subject will do well to acquaint themselves at first hand with the views of an author who has long ago established his name as an authority in infant feeding. It might be mentioned in passing that a French apparatus was described in another section of the Congress, the Salvator, which was said to be able to sterilise milk rapidly in any quantity. If that be so, the problem of municipal milk supply will be greatly facilitated. It is to be hoped that ere long the public conscience will be aroused as to the massacre of infants that is going on daily in its midst. Meanwhile the patient, self-sacrificing labours of scientific men are doing much to unravel the thousand-and-one perplexing coils beneath which this great and vital question is for the present well-nigh hopelessly hidden.

MUNICIPAL MILK

To preach to medical men the virtues of a healthy milk supply is to preach to the converted, but, unfortunately to the outside public the voice is as one crying in the wilderness. The excellent societies and guilds that make it their business to try to improve the conditions under which workers live have this subject much at heart. It is important, however, in every fight to measure the prowess of one's adversary, and when one contemplates the forces arrayed on the side of the dairy interest, it is hardly surprising that little progress is made. A peculiar difficulty lies in the heterogeneity of these forces; no one organisation is concerned, but many of different types and calibres. The temperance reformers find the trade they attack one self-contained entity, but milk-reformers are denied that privilege, and have to attack their foes in detail. The farmer apologises for his faults by pointing at the railway companies; the railway companies blame the dairy companies; and the dairy companies hark back to the farmer. Consequently a vicious circle is formed which it seems as difficult to break as it is to fix individual responsibility under the cunningly devised system prevalent at the War Office. Eyes naturally turn to the public authorities charged with the execution of the Dairies, Cowsheds, and Milk Shops Orders of the Local Government Board, but admirable as the intentions of these orders are, they are notoriously limited in scope and clumsy in practice. In most parts of the country the orders are wielded with so tender a hand that they are practically a dead letter, and even when administered with some vigour, as in certain larger towns, their operation is found to affect but the fringe of a great question. It is in fact becoming increasingly evident that if the milk trade is to be placed on a satisfactory basis—that is, if pure, fresh, uncontaminated milk is to be available at a price within the reach of the poorest, an effort of far greater force and effect than anything yet attempted will have to be put forth. Such an effort can be directed at its objection in one or two ways—either by a frontal attack or by a flank movement. To adopt the former a storm of public indignation and determination would have to arise in such force as to carry all before it. Dairymen and dairy companies will have to be attacked by every process of law and public opinion till they capitulate without discretion, and find for their clients farms where sanitation is above reproach and cows are groomed with the attention given to race-horses, with vessels sterilised and sealed throughout the whole course of their wanderings, a railway service providing cool and rapid transit by train, and honest retailers and distributors, who have either no opportunity of diluting or adulterating the milk, or no interest in doing so. In spite of all that has been written and said on the subject, we fail to discern any indication of such a storm on the horizon; the sleeper merely stirs when roused, and turns uneasily on to the other side. The second method of which we have spoken, namely, that by flank movement, is the one to which indications at the moment point, and it is the one which is most in consonance with the present trend of affairs. By flank movement we mean a gradual replacement of the private vendor by the municipality. Liverpool, Battersea, St. Helen's, and Bradford, to name only some of the leading towns, have of late years established milk-depots for the supply of sterilised milk to the poor under the tutelage of their sanitary committees, and though such enterprises are doubtful commercial ventures, these towns claim a sensible reduction in the diarrhœa death-rates among the infants fed with their milk. At Rochester, in the United States, an elaborate and carefully managed municipal milk-supplying system has been set on foot, and every detail in connection with the production and distribution is worked out in careful fashion, but the municipalities in this country have so far had to content themselves principally with obtaining ordinary commercial milk and sterilising it for themselves. The drawbacks to such a plan are obvious, and there can be no doubt that the next step will be towards the Rochester plan, whereby the municipalities own their own farms and are responsible for the whole milk traffic. Now, municipal trading is strongly opposed by a large section of the community, but in the case of a necessity as vital to the well-being of the nation as milk is, political inexpediencies are preferable to physical detriment, and if the future brings forth the municipal milk-can and the half-yearly milk-rate, the apathy of the public will have itself only to thank. The purveyors of water, gas, traction, and electricity have, by default, found these enterprises pass from sources of private profit to themselves into the property of the public, and if the milk trade makes a similar change of allegiance, there will not be many tears shed by hygienists. That milk produced under ideal conditions can be supplied at a profitable rate has been shown at York, and again at Copenhagen, where a private company pays a 5 per cent. dividend in spite of its additional expenses. There should, therefore, be no reason on the score of expense why the supply of milk should not pass into public hands. In the meantime, with all the horrible reports of filth and disease connected with milk constantly coming to hand, the only avenue of safety lies in sterilisation. This process can be admirably carried out by the Salvator apparatus, as announced at last week's Public Heath Congress in London, without any noticeable change in the quality or flavour of the milk, and the immunity it confers is absolute.

Notes on Current Topics.

Personation of a Medical Practitioner.

A remarkable case of personation has recently come to light at Gravesend, when last week a man was charged before the magistrates with forging a death certificate and committing perjury. A few weeks ago, Walters, who was a stranger in the town, called on a Mrs. Cohen, wife of a tradesman, and attended her on the representation that he was a qualified practitioner. Mrs. Cohen subsequently died, and Walters gave a certificate stating that death was due to pneumonia. Owing to certain suspicious circumstances attending the death an inquest was held. Walters attended as a witness, and said he was the person mentioned in the *Register* as Arthur Peacefield Walters, M.R.C.S., L.R.C.P., of 11, Beaufort Road, Clifton. He received a guinea for attendance, and signed the receipt. At the magisterial inquiry the real Arthur P. Walters appeared and stated that he was now practising in Scotland, and the address in the *Register* was that of his sister, given while he was travelling abroad. His diploma as well as three letters and his birth certificate, found on the prisoner, were at one time his property, and he was not aware he had lost them. He did not know accused and could only surmise he must have sent in the documents when applying for some post or other and that they had not been returned. It is not a little disquieting that that gross personation of this kind should have been disclosed by the merest accident. The General Medical Council, whose duty it is "to look after the *Register*," adopts no precautions whatever to guard against personation. A systematic inspection of signatures of death certificates would doubtless reveal similar abuses. Some day perhaps the Medical Defence Union, our ever present refuge and hope, will confer upon the profession the immense boon of a systematic record of names of persons who sign death certificates. Somerset House might possibly help.

Inebriate Reformatories.

The inebriate reformatory is still more or less on its trial, and there are not wanting critics, lay and medical, who have not much faith in its future. Certainly its task is not a very hopeful one under the present state of the law and in the prevailing temper of certain magistrates. Before the inebriate reformatory is condemned it should be given a fair trial, for it is not often that it gets inmates whose condition can reasonably be regarded as capable of real amelioration. In Dr. Branthwaite's Report under the Inebriates Act he relates the case of a stunted, imperfectly-developed woman of forty-three who had been before the police courts 219 times for the following offences :—Drunkenness, with or without disorderly conduct, 180 times ; assaults, 10 times ; larceny, 9 ; wilful damage, 12 ; prostitution, 6 ; causing obstruction, 1 ; offence against the Licensing Act, 1. Her first conviction was at the age of seventeen, and altogether she had been convicted 198 times and had spent over sixteen years in prison. She was then sent to a reformatory for two years, and on her release relapsed into the old life. The futility of expecting a reformation in such a character in two years must be obvious to the meanest intellect. On the other hand, the case is quoted of a younger woman who gave way to drink, and was convicted three times in the course of four years, and finally sent to a reformatory for three years' detention. This woman since her release has been living a sober, industrious life, and has not touched liquor since. Dr. Branthwaite pleads for cases to be sent early in their career and for long periods, before the expedient of short police court sentences has degraded and hardened the offenders. The reformatory, to be a success, must be treated fairly by committing authorities, and not looked upon as a *dernier ressort* for the hopeless drunkard.

"Bile Beans."

SOME interesting revelations were made in the action taken last week by the Bile Bean Manufacturing Co. to protect the title "Bile Beans." It appears that this well-advertised nostrum is put on the market by two gentlemen named Gilbert and Fulford, who apparently constitute the "Manufacturing Co.;" and is made from a formula drawn up by the latter gentleman. He is the "Charles Forde" described in advertisements as "a great scientist," although his partner was obliged to admit that, as far as he knew, Fulford had no scientific training whatever, unless a few years' work behind a druggist's counter was to be so designated. Of other training or study in chemistry or materia medica in any university or school he had none. Of an extract from an advertisement which referred to Captain Cook's discoveries in Australia, and his observation of the healthiness of the natives there, which was due to the medicinal properties of the indigenous plants, and Charles Forde's idea that these plants might be made useful to civilised men and women, Gilbert had to admit that there was nothing authentic but the reference to Captain Cook. He declined to say whether Australian plants entered into the composition of "Bile Beans," but neither he nor his partner had ever made any extensive inquiry into the medicinal properties of Australian herbs. Much stress was laid by the proprietors on the peculiar and ingenious shape of their product, so that they must have been taken aback when the presiding judge compared its appearance to that common object of the barn floor which indicates the vicinity of the ordinary rat.

Sterilisation of Degenerates.

ALTHOUGH the reception generally accorded to Dr. Rentoul's proposal to "sterilise" those harmful members of society who hand down their vicious traits to their offspring, was, and still is, a cold one, we notice that the seed he has sown has not fallen altogether on stony ground. In the Annual Report of the Gloucester and County Lunatic Asylums, the medical superintendent, Dr. Craddock, in speaking of the increasing amount of accommodation that is necessary for the insane in his county, warmly advocates some system by which physical means should be used to prevent the unfit from producing children. Dr. Craddock is much impressed with the influence of heredity in the production of insanity, and also with the increasing hopelessness of the cases that come under his notice. With these facts constantly before his eyes he urges that duty lies in the use of measures for the prevention of insanity quite as much as, if not more than those of attempted cure, when cure is so remotely to be hoped for. He fears that public opinion is not sufficiently advanced to adopt Dr. Rentoul's remedy, and he sees but one possible alternative, namely, the life-long segregation of the unfit. The cost to the community of the latter plan would naturally be immense, if we accept Dr. Rentoul's carefully collected figures. These show that one in fifty of the population of the country is mentally degenerate, and no less than one in five is physically diseased—or undeveloped. The whole subject bristles with difficulties and prejudices, but we hope that the Royal Commission on the Care of the Feeble-minded, which is now sitting, will find some way by which imbeciles and half-witted girls can be prevented from bearing illegitimate children to unknown fathers in the appalling way that they do now. If a beginning could be made with this unfortunate class, the larger question might be gradually attacked.

The Psychology of Anæsthesia.

Two centuries ago it was a moot question among philosophers, "Does the soul always think?" Though apparently the question was quite satisfactorily answered in the negative, at the present day again it may deserve consideration. This is due particularly to the fact that during recent years, with the discovery of the large field of sub-conscious psychical phenomena, the appeal to consciousness loses its finality in answering questions in psychology. There is, indeed, in modern psychology no more interesting branch than this of the sub-conscious, and it may be argued with show of reason that sub-conscious psychical activity is always present, and consequently that "the soul *does* always think." Whether this be so or not we leave to the philosophers and psychologists, but the latter have recently requested the assistance of physicians in the study of a point which may have some bearing thereon. Professor Jastrow, who occupies the Chair of Psychology at Wisconsin, suggests that a useful series of observations might be made on persons undergoing anæsthesia for surgical purposes, particularly in the process of "going under" and "coming to." He suggests certain details on which information might be gathered, such as the degree of suggestibility of the patient, and the possibility of the production of automatic acts during light anæsthesia. The observation of such phenomena as automatic talking, mechanical acts, tricks of manner, and so on, may give some help in the elucidation of the processes of sub-conscious psychical activity. The recollections of an intelligent and instructed patient of his own experiences would also be of use. We have no doubt that there are many practising anæsthetists who would be glad to co-operate with Professor Jastrow in the interesting research he suggests.

Liquid Air.

SINCE the discovery of the liquefaction of atmospheric air, but few attempts seem to have been made to use the fluid in the treatment of disease. In the *Medical Record* for July 8th there is a suggestive paper by Dr. William Trimble, of New York on therapeutical applications of liquid air in dermatology. The conditions in which he has used it are chiefly those in which other measures have been disappointing or inapplicable. Five cases of pigmented mole are recorded, in all of which the result of the treatment seems to have been satisfactory. The liquid air is brought to the clinique in a Dewar's tube, and it is applied to the part to be dealt with by means of a swab of cotton-wool fixed on to a long stick. Varying degrees of pressure are used in applying the air and for various lengths of time. Light pressure causes slight reaction and inflammation ; medium pressure, ulceration with superficial sloughing ; hard pressure, deep sloughing. The part touched is instantly frozen and becomes quite hard, and if medium or hard pressure is used, obliterating endarteritis with necrosis of the tissue is brought about. Scarring to a greater or less extent results, but if the applications are infrequent and spread over a long period of time, the scarring is reduced to a minimum. The liquid, from its intensely low temperature, acts as an anæsthetic and no pain beyond slight tingling and burning is felt. Two cases of epithelioma of the face are related ; the first of these healed completely after two applications ; the second, which had failed to respond to X-rays, was cured by one. Two patients suffering from nævus vasculosus (strawberry mark) and two from lupus erythematosus did well, but their cases had not all been completed at the time of report. There would seem to be little doubt that in liquid air we possess a medium whose usefulness is well worthy of further investigation.

The Fourth of July and Tetanus.

THE returns of accidents due to Fourth of July celebrations in the United States have not yet come to hand, but we hope that the number of fatalities may show a decrease corresponding to what was noticed last year. In 1903 the number of persons killed as the result of firework celebrations on the Fourth was 466, while in 1904 it had fallen to 183. There were in each year in addition about 4,000 cases of serious accidents not resulting in death. The decrease in tetanus, too, was considerable ; in 1903 there were 415 fatal cases reported, while last year there were only 105. There is no doubt that this improvement is due in great part to the energy of the medical papers of the States in preaching a crusade against the blank cartridge, the special engine in the production of tetanus, and in instructing laymen and medical men alike in the steps that must be taken to avoid the disease. Formerly, the wound of the palm caused by a blank cartridge was in most cases treated by household dressing, and even if submitted to a surgeon it received little more attention. It has, however, been impressed on the surgeon that all wounds such as may give rise to tetanus must be thoroughly cleansed to their depths, and on the parent that the aid of a surgeon should in all cases be invoked. The greater attention, however, given by parents to the dressing of wounds, in cases where a surgeon's assistance is not called in, has had its drawbacks. Very often excessively powerful antiseptics, such as strong solutions of carbolic acid, have been employed, to the great damage of children's hands, gangrene having ensued in several cases. It is unfortunate that a great nation cannot celebrate its festivals without the sacrifice of children's limbs and lives, but we hope that, owing to better instruction, the holocaust may this year again show a diminution.

Pathology of Cerebro-spinal Meningitis.

THE recent epidemic of cerebro-spinal meningitis in Silesia has afforded plenty of material for the study of this little-understood disease, and a report by Westenhöffer, which appears in the *Berlin Klinische Wochenschrift* for June 12th, contains some interesting observations. The most important of these has resulted in his being able to trace the path of infection, which is still held in much doubt by competent scientific Americans who have had the opportunity of making pathological researches on those who have died of the disease. Westenhöffer asserts that the posterior nares and especially the pharyngeal tonsil, are the paths of entry, and that by infection of the lymphatic and basic meningitis, starting in the region of the pituitary body, is set up. He holds that the meningitis rarely or never arises through extension of the inflammation from the ethmoidal cells. The disease, therefore, is contracted by inhalation of the organism ; the patients are chiefly children. He found the diplococcus intracellularis meningitis in most of the cases he examined, but many other cocci were associated with it, and he does not consider the evidence of Weichselbaum's organism being the only, or even the chief, causative agent as conclusive. With regard to prevention, Westenhöffer points out that as the disease is one contracted by inhalation, the principal measures to combat it are those which aim at rendering the interiors of the houses clean and healthy. Grawitz, in the same journal, enters a protest against the name "epidemic" cerebro-spinal meningitis being used for a disease whose manifestations are chiefly sporadic, and suggests the term infectious or contagious meningitis. The latter are certainly more accurate, and have the additional advantage of not being cumbersome.

Criminal Charge Dismissed.

THERE seems to be no end to the monstrous charges which people prefer against medical practitioners, and the only satisfaction that can be derived from the contemplation of them is that juries have the good sense to see through these worthless actions. At the Winchester Assizes, on the 6th and 7th of this month, the trial of an action against a Gosport doctor for damages for seduction was heard before Mr. Justice Bigham.

The case had been tried previously, but upon that occasion the jury had been unable to agree. The plaintiff was a fishmonger, and his daughter alleged that after two operations had been performed on her throat by the doctor, she paid him several visits at his surgery. During these visits the defendant made overtures to her, and finally seduced her. A further suggestion was made that the doctor had given her certain drugs when he was informed that she was pregnant. These drugs had been analysed and were found to contain nothing more harmful than magnesium sulphate and myrrh. The plaintiff's daughter's evidence was uncorroborated, and after hearing the opening remarks of counsel for the defence and the doctor's formal denial of the charge, the jury stopped the case. The judge, in giving his verdict for the defendant, said that he quite agreed with the view the jury had taken. However careful a doctor may be, it is always open to malicious and unscrupulous females to invent charges of misconduct, and it is of the highest importance to the honour and dignity of the profession that these charges should be met with a bold front and fought to a finish. The doctor in this case was defended by the Medical Defence Union, who have done such excellent work in protecting practitioners, and whose name is justly feared by adventurers and blackmailers.

Plasma as a Therapeutic Agent.

Antitoxic sera of various sorts have now so firmly taken their place in medicine that it is right that we should understand not merely the therapeutic action of the antitoxin, but that of the serum which is its vehicle. To this end Mr. Montgomerie Paton has been engaged for some years in the study of the therapeutic action of simple plasma, and he has made known his results in a recent paper (*a*). He has come to the conclusion that the nutritive value of plasma administered by the mouth is greater than has usually been supposed. In suckling mothers, where lactation is for any reason defective, the regular administration of plasma is found to act promptly and vigorously in producing normal secretion, and in maintaining it for the necessary length of time. Even in the case of mothers previously weakly a better condition of health is produced, and the baby's nourishment is all that can be wished. In some cases so marked was the improvement in mother and child that the mother thought it unnecessary to continue the treatment, with the result that her health again failed. In many cases of debility, particularly in the very young and the very old, after, for instance, acute infective diseases or operative interference, plasma appeared to give very beneficial results. Mr. Paton has made use of it in very varying clinical conditions—splenic leukæmia, chronic nephritis, tuberculosis, and in no case has he thought its effects unsatisfactory. His proofs are, of course, not quite conclusive, but there are no doubt many physicians willing to test the value of plasma in their own practice, so that we are likely soon to obtain fairly certain results. The plasma of the sheep is probably the easiest to obtain, and is said to have as high nutritive properties as any other.

Rectal Feeding.

In many conditions of the stomach, such as cancer or ulcer, it is impossible to give any but the simplest foods by the natural channel, and in recent years the tendency in such cases has been to abandon oral feeding altogether in favour of feeding by the rectum. It is possible that this method has been carried too far, and it is certain that in many cases attempts have been made to administer by the rectum foods which cannot there undergo absorption. It is necessary in rectal feeding to remember the limits imposed by the disabilities of the large intestine in the matters of digestion and absorption. In the ordinary course of nature no digestion takes place in the large intestine, and it is doubtful whether this part of the alimentary canal has, in fact, any digestive powers. In the ordinary course, too, it is probable that no absorption, except of water or salts, takes place in the large intestine. There is therefore every reason to expect the easy absorption of water or saline solutions when administered by the rectum, while there is no reason to believe that foods which require digestion can be of any use when given in this way. In fact, most physicians who take the trouble of inspecting the excreta of patients undergoing rectal feeding have learnt that practically all the solids administered as food are returned unaltered, but deprived of their fluid accompaniments. Nevertheless, recent investigations by Edsall, Miller and others go to show that fats can be absorbed in fairly large amount if administered in the form of soap, and it is probable that if rectal feeding is to retain its ground in the treatment of gastric disorders, it will be in this form that foods must be administered.

American Spelling Again.

The Editor of the *American News* in a recent issue, publishes another gibe against English medical men for their audacity in condemning the American orthography, which he so faddishly affects. What authority, however, has he for saying that this orthography displeases " a small class of English ultra-conservatives ? " As a matter of fact " this small class " only consists of the whole British medical profession. Nothing is more irritating to most educated and progressive authors and editors, to quote his own words, in this country, than to have to read sentences made up of mutilated English words with which certain American authors convey their meaning. Thus an example : " Say, doc, in my opinion, the physic signs are mostly medic, and neither surgic nor gynæcic." " Cemic " for chemical is another beautiful expression arrived at by the clipping of the " al." But how " gynæcic " for gynæcological

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(a) *Intercolonial Med Jour. of Australasia*, April, 1905.

can be accounted for etymologically, surpasses our comprehension. Again, some elegant words are made in America by leaving out the unassuming hyphen, such as "medicolegal" "proofreaders," "nonobservance," all of which, and many more, are common to readers of *American Medicine*. While "sulfate," "chlorid," "sulfuric," are other instances of labour-saving words. But if "chlorid," why not "suicid"?—that is just the point— The difficulty is to find any reason for all this clipping; still, it may be that the wages bill for the compositors are a great drain upon the finances of the medical journals published in America, and so, in the cause of economy, this clipping and chopping of English words and unnecessary mutilations may have a sound basis from an economic point of view. However, the readers of *American Medicine* are occasionally indulged with the hyphen, for on one page in a recent issue one comes across "fare-mindedness"—not quite an English word anyway, and "self-doping," whatever that may mean in America. The curious point, however, about all this medical orthographic mania in America is that the lay journals of the country never inflict such eccentricities and barbarities upon their readers. Why, then, we may ask, should the medical profession be subjected to such an irritating style of orthography?

The Scalp Isolation of School Ringworm.

One of the most practical papers read last week before the London Congress of Public Health dealt with the important subject of school ringworm. It will be found reported in another column. Its author, Dr. David Walsh, therein described a new method which bids fair to revolutionise the attitude of school, no less than of public health, authorities with regard to this widespread disease of town children. Medical men insist that no child suffering from ringworm should be allowed to attend school. But under the most skilled treatment the disease lasts from six months to two or three years, or more. To exclude ringworm children, therefore, would be to deprive a vast number of them of the greater portion of their school life. But often-times Mahomet may go to the mountain when the mountain cannot come to Mahomet. Dr. Walsh encloses the shaved scalp in a film of collodion or other impervious adhesive material. The scalp may then have a few cautious exposures to the X-rays, but this step is not indispensable. Every ten days the cap-film is gently stripped off and on its shaggy undersurface will be found a great mass of healthy and diseased hair stumps. By this wholesale depilation cure is materially hastened, but there is no fear of permanent baldness. The great feature of the discovery, however, is that while wearing the cap-film a child may be allowed to attend school, for the scalp by reason of its impervious envelope is absolutely prevented from spreading infection. In London it would be easy to start central depots under expert medical supervision, whither ringworm scholars could be sent every ten days or so for treatment by Dr. Walsh's method, which, so far as we can see, offers a probable solution to one of the knottiest problems of school administration.

The Ice-Cream Season.

THE ice-cream harvest is now in full swing, and swarthy Italians are waxing fat in the garnering thereof. Whatever view the man in the street may hold as to the wisdom of excluding aliens from the shores of our tight little island, there can be no two opinions as to the need of regulating these trade operations if carried on to the danger of the health of the community. Yet ice-cream vendors too often spread disease and death far and wide in the course of their unwholesome traffic. Again and again it has been shown that the milk, the flour, the water, the ice, and other ingredients of their pestiferous dainties are kept in filthy garrets and courts and under conditions that are simply revolting to every sense of sanitary cleanliness. The vessels in which the ices are made are unclean beyond belief. What wonder if under these circumstances their ices contain germs of typhoid fever, diphtheria, bowel organisms, and many other disease-producing bacteria in hosts. Last but not least they are as a rule sold to children in small glasses from which they are actually lapped up by the unhappy little customers. In Birmingham recently two hundred children were poisoned by the polluted products of a single "hokey pokey" barrow. It is high time that local authorities imposed stringent regulations everywhere to control this most undesirable species of alien enterprise. Medical science has revealed the danger, lock, stock and barrel. It now remains for the civic authorities to act on the information and look to their by-laws.

Cigars and Bribery.

THE medical profession, sooth to say, is exploited on all hands by what the stockbrokers would call "bucket-shop" keepers. Out of our medical charities many fortunes are made by contracts of drugs, meat, groceries, milk and what not; lawyers make huge sums by managing mortgages, conveyances, and so on of property that in almost incredible bulk belongs to richly-endowed hospitals like St. Bartholomew's and Guy's; nursing journal editors make enormously valuable properties by exploiting the hospitals and obtaining their advertisements at high rates; society folk and City men get huge slices of patronage and angle, not unsuccessfully, for social prominence and titles. It is medical men generally who, so far from getting anything out of the medical charities, find in those institutions their keenest rivals, eager to rob them of their poorer patients by the pernicious pay system that permits Guy's Hospital and the London to take the pence of the poor with unblushing face, although the public pour hundreds of thousands of pounds into their coffers for the relief of the poor. Among the unceasing exploitations comes a peculiarly degrading one in the shape of an enterprising cigar merchant who offers all medical men a reduction of 30 per cent. on his particular brand of cigars if the purchasers will recommend their wares to their patients. Knowing the ways of commerce, it is fairly self-evident that the merchant will lose nothing out of pocket in sacrificing 30 per cent. from retail prices. *Truth*, ever ready to take up the cudgels on behalf of the medical profession, has fearlessly and continuously exposed artifices of this kind, and naturally advises patients to beware of advice as to cigars coming from their medical men. We trust for the honour of our profession that no such meretricious advice will be forthcoming.

PERSONAL.

UNDER the auspices of their Majesties the King and Queen, it was recently decided that a new Red Cross Society be formed to co-ordinate all those existing societies concerned with the succour of the sick and wounded in war. A Council has been appointed by their Majesties, under the presidency of the Queen, with Lord Rothschild as chairman, and Lord Knutsford, Lord Esher, Lord Cheylesmore, and Mr. A. Loyd, M.P., as vice-chairmen.

H.R.H. PRINCESS CHRISTIAN, who was accompanied by her Highness Princess Victoria of Schleswig-Holstein, on the 17th inst. presided over a meeting of the Executive Committee of the National Committee for the Establishment of Sanatoria for Workers Suffering from Tuberculosis.

OWING to an epidemic of rabies in Penang, which has already resulted in four deaths, it is announced that Leong Fee, the Chinese Consul, has offered the Government to build and equip a Pasteur institute for the Straits Settlements and the neighbouring regions.

DR. CHARLES O'REILLY, of Toronto, is the Canadian delegate to the British Medical Association meeting this week at Leicester.

ON the 16th inst., the Duchess of Westminster opened the new maternity wards at the London Hospital.

THE French Ambassador, M. Cambon, recently unveiled at the French Hospital, Shaftesbury Avenue, a statue of the late Dr. Achille Vintras, its founder. The statue, which is the work of M. Lenteri, is in bronze and bears an inscription in French to the following effect : 'To Doctor Achille Vintras, Founder and Physician-in-Chief of the French Hospital in London, from the grateful French Colony."

AT a meeting of the Court of Edinburgh University on July 17th, the resignation was intimated and accepted of Professor Alexander Russell Simpson, who has filled the Chair of Midwifery for thirty-five years.

MR. ERNEST POWELL KING, of Wainsford, near Lymington, whose will has now been proved, left £100 each to the London Temperance Hospital, the National Hospital for the Paralysed and Epileptic, Queen Square, and the Royal South Hants Infirmary.

DR. HOWARD A. KELLY, of Johns Hopkins Hospital, Baltimore, was among those who received the Hon. Fellowship of the R.C.S.Ed., on the occasion of the Quatercentenary.

SIR RICHARD DOUGLAS POWELL, M.D., President of the Royal College of Physicians of London, has been unanimously elected an honorary Fellow of the Royal College of Physicians of Ireland.

DR. C. H. C. FARQUHARSON has been appointed District Medical Officer at Port Maria, Jamaica, in place of Dr. J. A. L. Calder, transferred to Santa Cruz.

DR. F. A. BALDWIN has been appointed Medical Officer of the Gambia, West Africa.

DR. D. J. WILLIAMS, Medical Superintendent of the Lunatic Asylum, Jamaica, has arrived in England on leave of absence.

THE French Académie de Médecine has awarded, through the Minister of the Interior, a silver medal to Dr. Alan B. Green, bacteriologist in charge of the vaccine lymph department of the Lister Institute of Preventive Medicine, for his work on "Vaccine."

PROFESSOR D. I. MENDELEEFF, the distinguished professor of chemistry at St. Petersburg University, completed the fiftieth year of his public professional services on June 13th. A celebration in recognition of his services will take place on August 30th.

British Medical Association.

SEVENTY-THIRD ANNUAL MEETING, JULY 24TH TO 28TH

[NOTES FROM OUR SPECIAL CORRESPONDENT.]

ALTHOUGH Leicester cannot offer the classic attractions of last year's meeting-place it is a prominent centre of activity and offers manifestations of progress which make it a welcome gathering ground for the representatives of British Medicine. Great efforts and elaborate preparations have been made to ensure a successful meeting. Both the profession and the public have done their best to provide hospitality, social delights, and sound scientific food for the numerous visitors who have come from all parts of the country to meet friends and discuss the many problems which cluster about the science and art of medicine.

Leicester is an excellent railway centre, and the great facilities for attractive travelling are bringing many visitors to this year's gathering. Whatever may be said of the permanent scientific value of the "Annual Picnic" it is generally admitted that it offers a most desirable opportunity for the renewal of old friendships and the making of fresh friends.

THE NEW PRESIDENT.

Mr. George Cooper Franklin, the new President, is a thorough representative of Leicester. Born in the borough in 1846 he has practised within its borders for 30 years, winning honour as a citizen and gaining respect as a trusted surgeon and medical adviser. He received his general education at Leatherhead, in Surrey, and at Stoneygate School, and his professional training at St. Thomas' Hospital in London. Mr. Franklin took his M.R.C.S. in 1870 and was admitted L.R.C.P. in 1871. In 1873 he was received after examination as F.R.C.S. Settling in his native town in 1875 he was soon appointed surgeon to the Leicester Provident Dispensary. In 1886 he joined the staff of the Leicester Infirmary; and now, after nearly twenty years of service, is senior surgeon. Although pre-eminently a surgeon, Mr. Franklin may be well characterised as an all-round practitioner, and it is interesting to note that from 1871-74 he was Resident Medical Officer to the City of London Hospital for Diseases of the Chest. Mr. Franklin, although by no means a voluminous writer, has contributed some valuable papers to scientific medicine. In 1875 in collaboration with the late Dr. W. E. Buck, he issued a "Report on the Epidemic Diarrhœa of Leicester." He has also written on "Intra-thoracic Disease," and "Criminal Abortion."

The President has also played a prominent part as a citizen of Leicester; and as member of the Town Council, Churchwarden, and supporter of many societies—professional, benevolent, and social—he has exercised widespread influence. In this instance at least a practitioner of medicine has won honour in his own country, and to-day he has the proud distinction of presiding over the largest and most representative association of medical men in this country.

THE WORK OF THE SECTIONS.

Although the programme of the scientific work of the sections does not promise any startling features, and in some respects is disappointing, there is evidence that the discussions which have been arranged for will be of service in reviewing and perhaps extending knowledge and improving our practical methods. It is much to be regretted that under the new regime the purely business matters of the Association monopolise an immense amount of the time of many, and some who might well be taking a valuable part in the scientific work of the sections are held captives in the meetings of the Council. A growing number of members make entertainments and excursions their main interest. Thus it happens that between business and pleasure scientific medicine is in danger of being neglected. The foolish and short-sighted policy of the powers that be in issuing the notice that "Papers read are the property of the British Medical Association and cannot be published elsewhere than in the *British Medical Journal* without special permission" has also done much to discourage the best workers from taking part in the proceedings. There are twelve sections, which meet on the mornings of Wednesday, Thursday, and Friday, July 26th, 27th, and 28th.

THE DISCUSSIONS.

Modern opinion and present-day practice clearly indicate that papers are of much less interest and service than suitably arranged and well directed discussions. The former can be printed and quietly considered as they appear in the pages of the *Journal*, but a discussion has wide educational value and does much to focus attention and energise effort along reliable paths. The discussions which have been arranged for promise to be of distinct interest, and no doubt will attract much notice. Sir Lauder Brunton is to open the discussion on the treatment of sleeplessness and pain; Dr. Howard Tooth speaks on the various forms of acute meningitis; Dr. Julius Dreschfeld deals with the diagnosis and treatment of cardiac degeneration. In the surgical section Mr. Moynihan will open the discussion on the surgical treatment of non-malignant diseases of the stomach; and Sir Charles Ball that on the treatment of malignant disease of the rectum. It seems likely that the section of state medicine will prove one of the most attractive departments, for here discussions have been arranged for on such much debated questions as—hospital isolation for infectious disease, sanatoria for the consumptive poor, infant milk depots, and, "What is notifiable diphtheria?"

In such a commercial centre as Leicester there should be much prominence given to industrial hygiene and diseases of occupation, and in the section devoted to these there are to be discussions on physical deterioration, anthrax, and accident and poisoning reports. The other more special sections offer attractive bills of fare which no doubt will provide select audiences of enthusiasts.

An attractive *Guide to Leicester and Neighbourhood* has been prepared by Mrs. G. Clarke Nuttall, B.Sc., and will prove invaluable as a concise and reliable handbook for visitors. The author, we understand, is the wife of a local medical man, and Dr. Reginald Pratt and others have assisted in its preparation.

The Temperance Breakfast organised by the Chairman and Committee of the National Temperance League has become a popular institution in connection with the Annual Gathering of the Medical Association, and this year the Dean of Hereford is to preside. The breakfast is held on Thursday, July 27th, at 8 a.m., in the Leicester Temperance Hall.

A number of Leicester factories will be open for inspection and should attract many who desire to observe for themselves conditions of industrial life and work.

The Pathological Museum is housed in a large room of the first floor of the technical schools and contains a valuable collection of gynæcological specimens and other preparations of pathological interest.

Receptions, garden parties, excursions, golf, and other delights have been arranged for, and in all probability will prove the most enjoyable and best patronised features of the Leicester Annual Meeting.

The Annual General Meeting of the Association was held in the Association Hall of the Leicester Y.M.C.A. on Monday afternoon. On Tuesday (July 25th) morning the new Council met and representative meetings were held. The customary religious services were conducted in the afternoon. Last night the President delivered his address, and there was the usual reception of distinguished guests. To-day (Wednesday, July 26th) the real work of the meeting begins.

Special Articles.

THE LONDON CONGRESS OF PUBLIC HEALTH.

The Annual Congress of the Royal Institute of Public Health has been held this year for the first time in London. It was largely attended and its organisation having been carried on on a comprehensive basis, the result must be of a most satisfactory nature to those concerned in the meeting. Proceedings began on Wednesday, July 19th, with an inaugural address by the Marquis of Londonderry, who at the same time opened a highly interesting exhibition at His Majesty's Theatre. Professor W. R. Smith was in the Chair, and formally welcomed the delegates and visitors to the Congress. Lord Londonderry delivered an interesting address on physical efficiency, and insisted on the need of educating the public in health matters. On the 20th, the Congress dinner was held at the Hotel Cecil, and was followed by a dance. Numerous excursions were organised to various places of interest, such as Taplow Court, Windsor, Burroughs Wellcome's manufactory at Dartford, the Downs Ringworm Schools, Hatfield, and a score of other places. On Sunday special services were held at St. Paul's and the Roman Catholic Cathedrals, as well as at the City Temple, Southwark Cathedral, and other churches and chapels. Scientific work began again on the 24th and 25th, and the Congress closed at the end of the latter day. As regards the sectional work, a number of first-rate papers were read in the various sections, which included Preventive Medicine, Municipal Administration of the Education Acts, Child Study and School Hygiene, Engineering, Bacteriology and Chemistry, Veterinary Hygiene. Practical Hygiene, Naval and Military Hygiene. The Section of Preventive Medicine was opened by that brilliant Nestor of Medicine, Sir J. Crichton Browne, who gave a characteristic address showing how the ideal average of life might be placed at a century. There were quite a number of papers by first-rate men dealing with sewage problems, especially in relation to river purification and sewage discharge. By some mischance, a bold suggestion advanced by Dr. Walsh that all sewage effluents should be sterilised by heat before discharge into streams, drifted into the Bacteriological Section. The last-mentioned section had some excellent discussions, one of them dealing with the possibility of establishing a bacteriological standard of purity for milk, opened by Professor MacFadyen, and maintained by Professor Kenwood, Nathan Raw, Dr. W. G. Savage, and others. Great interest and activity was manifest in the Veterinary Section, and some excellent papers were contributed dealing with meat and milk problems. In the Tropical Hygiene Section, one of the best contributions was on tropical life insurance by Mr. James Cautlee. In no section was better work done than in that devoted to Child Study and School Hygiene. Dr. George Carpenter, one of the Hon. Secretaries, read a valuable paper on the present high infantile mortality rate. Another important contribution was that of Postural Defects in Children, by Mr. Alfred Tubby. Among many other valuable papers was one by Dr. David Walsh urging the isolation of individual scalps in children, who might then be sent safely to school. This principle appears not unlikely to revolutionise school ringworm. The Child's Section was presided over by Lord Stanley, who delivered the kind of wise philosophical address one would expect from an educationalist of his great experience and culture. Altogether the Institute of Public Health may be congratulated on having achieved a most brilliant and successful Congress.

Correspondence.

IN DEFENCE OF THE PESSARY.

To the Editor of the Medical Press and Circular.

Sir,—Having read with interest the valuable paper by Dr. Granville Bantock on the above subject in your last issue, I venture to notice a few points. Having myself been able to give more relief to females suffering from various symptoms due to misplacements of the uterus, by means of replacement and a properly adjusted pessary, I naturally agree with much Dr. Bantock states (though I fancy it is some time since the paper was written, no date being given). I have always maintained that *true displacement of any form does not exist with a healthy uterus*, and the frequent existence of abnormal secretion alone would show this. I can quite understand the advocates of operation as a cure? for displacement, upholding their views, when such a man as Marion Sims can state "It has frequently taken me a fortnight and sometimes much longer, to adjust an instrument accurately, and sometimes it has been utterly impossible for me to do it at all." (page 280). Is it any wonder then, gynæcologists of the present day, finding themselves in a similar position (instead of recommending a brother practitioner, who understands the value of pessaries, andwho might succeed, and save the patient, expense, pain and risk), at once resort to operation? (It might be considered unkind should I suggest that an operation would pay better, and we all know it is easier to cut a cord than to untie a knot.) Call it "suspension" or "fixation," is it common sense to tether an organ (meant to have free movement) for all lifetime, when the same result can in *almost all cases* be attained by care, skill, and a well-fitted pessary? I quite agree with Dr. Bantock in his wholesale condemnation of ring pessaries (above all, the rubber form). As I pointed out myself years ago, the vulcanite pessary can be softened in boiling water, moulded to the shape required, and then dipped into cold water, when it will retain its shape. The advantage of the block-tin instrument over it being: *It can be bent by the fingers after introduction* and retains its shape, and I have thus succeeded where the vulcanite instrument has failed.

I have found it a good plan, when the patient is fitted with pessary in consulting room, to ask her to drop down in sitting posture on a hard chair. If any complaint is made, the pessary does not fit and should be readjusted.

Should the percentage of failures by the suspension or fixation treatment of flexions, &c., increase, I presume the next step will be alteration of the female pelvis.

I am, Sir, yours truly,

July 20th, 1905. Alexander Duke.

To the Editor of The Medical Press and Circular.

Sir,—I agree with the greater part of Dr. Bantock's very able paper on the above subject in your issue of the 19th inst., and, referring to his last paragraph, I do not consider he has used expressions one whit too strong, having regard to the importance of the subject and the ignorance often displayed in the treatment of displacements and flexions of the uterus. I would like with your permission to make a few remarks on the paper in passing.

I think in the first place, since gynæcology has drifted so much lately into the domain of surgery, that practitioners do not exercise the sufficient patience that the proper treatment of such cases entails, and so they betake themselves to the route that holds out a prospect of *cure* in the shortest possible time. Dr. Bantock remarks: "No work with which I am acquainted, with the exception of that of Hart and Barbour, clearly observes this distinction"—that between *retroversion* and *retroflexion*. I wish to draw attention to the fact that in my book, "Practical Gynæcology," I make the distinction very plain, giving separate sections to each condition. With regard to anteflexion, the condition of the fœtal uterus is that of antecurve, the cervix being as long as the body.

One word with regard to the Albert Smith-Hodge pessary. I devised and used at the Hospital for Women, the double curve, rendering the Hodge more effective in maintaining a retroverted uterus in its normal position, before I was aware that Albert Smith had suggested the same improvements, so that the present form may be acknowledged as a *Double Smith-Hodge* pessary.

I do not agree with Dr. Bantock that "retroversion with anteflexion is so very rare." I have not unfrequently found an anteflexion with the os uteri pointing towards the pubes, so that the lower portion is in a position of retroversion while the fundus is anteflexed. I quite agree with Dr. Bantock that to insert a pessary without first replacing the uterus, in the hope that it will restore the uterus to its normal position, shows lamentable ignorance, as also it does to put it in upside down!

Dr. Bantock rightly advocates the use of the sound for the replacement, and if the operator has a light hand, or if, finding the uterus tender, he first of all reduces the inflammatory condition, no harm will ensue. His directions as to the way the sound is to be used for the replacement leaves nothing to be desired. Dr. Bantock is rather hard on the "ring" pessary. I have found it of great service in some cases of early procidentia, and also in prolapse of the vaginal walls, but he is quite right when he says that "it is impossible for a ring pessary to cure a simple case of retroversion."

These vaginal pessaries are absolutely useless to restore cases of anteflexion; nothing will do but some form of intra-uterine stem. In many cases where the os uteri is very small and the canal narrow, merely to dilate the canal with graduated sounds is only of temporary service; the uterus soon returns to its former condition. I have found the best plan is to dilate, then make two *slight* incisions inside the canal, forcibly dilate with Marion Sims' "glove-stretcher," which slightly tears the cervical fibres, and then insert a glass stem for a few days, when the dilatation will remain permanent, and pregnancy, often impossible before, will supervene.

I quite agree with Dr. Bantock that when a retroversion is complicated with adhesions, it is quite possible after appropriate treatment to be able gradually to restore the uterus to its normal position.

With regard to the best material for pessaries, I unhesitatingly give the preference to the plastic celluloid, *i.e.*, soft celluloid with a wire core; and when the proper size and shape have been ascertained, and the patient is able to wear it quite comfortably, *i.e.*, almost without being aware of its presence, a hollow aluminium one should be made to the exact pattern, and this by its lightness and cleanliness will greatly conduce to the patient's comfort.

I am, Sir, yours truly,
Heywood Smith.

Welbeck Street, London, July 22nd, 1905.

THE CANCER PROBLEM.

To the Editor of The Medical Press and Circular.

Sir,—I was privileged forty years ago to attend the wards of the Middlesex Hospital, and was much impressed with the masculine type of the women who suffered from cancer. The incidence of cancer is mostly after the cessation of the great and widely corelated—nay, cosmic—phenomena of maternity. It is then that the "energies" which have, up to 40 or 50 years of age, made for the greatest of all the processes and purposes of life, take in a different direction, and there often results the exuberance of cell development known as cancer.

Histologically, it is not possible to conceive that the cosmic energies which produce the sexual system, and the capacity for maternity, stop abruptly with the cessation of the monthly and ovarian functions; a *reliquiæ*, in biological continuity, must survive, and which seem to find their expression in the cell development of different layers of the blastoderm, especially of the epiblast and its differentiations. In walks through the country, one may see "wild"—*i.e.*, naturally situated and treated—plants, run to a great exuberance of growth after the period of their flowering and fructification. Is the exuberance of cancer-cell growth parallel with such phenomena in plants?

I would venture to suggest the administration of ovarian tissue and its "modes" to a series of cancer cases, in women who have passed the age of child-bearing; the idea being, that, by even a most partial restoration to the system of its former "modes" and corelations, we might alter the metabolism and divert the "energies" which determine the epithelial cancer-cell evolution back into their old channels of harmonious corelation and continuity. Many analogies point to such a general method. Biology is full of instances of the intimate and essential corelations of the functions and structures of the system. We may not hope at present to compass the law and ratio of the organic evolution, to do in biology what Kepler did in celestial motions, or Grove did in the "corelation and continuity of the physical energies," but we may fairly hope for increasing light on biological corelations and continuity, attained by observation and analogy.

Darwin has given us a vast series of illustrations of how small changes of inner and outer environment determine the greatest variation in plants and animals, from the paleoneological series down to our present fauna. Observation of Nature and analogy may lead us to discovery long before we have unfolded the chemical or cellular continuity.

I venture to make the suggestion of the administration to women of ovarian cell modes and "motions"; and to men at the ages of decay of the sexual powers, of testicular modes and energies.

If it fail, others may be led to see and think more clearly and accurately.

I am, Sir, yours truly,
William H. Pearse.

Plymouth, July 20th, 1905.

Obituary.

JOHN JAMES RUTHERFORD, M.D.St.And., F.R.C.P.Ed.

It is with regret that we record the death of Dr John James Rutherford, of Shipley, which took place at his residence on the 16th inst. Dr. Rutherford, who was one of the best known men in the Shipley district, had been failing in health for a considerable period, and it had been known for some time that there was little, if any, hope of his recovery. So long ago as in 1900, Dr. Rutherford had the misfortune to contract blood-poisoning during an operation, and he was then for some time seriously ill. Born at Kirkmichael, in Dumfriesshire, in 1846, Dr. Rutherford was in his fifty-ninth year. He was, of course, one of the oldest medical practitioners in the town, and his practice extended for a long time over a wide area. For six years Dr. Rutherford occupied the position of Medical Officer of Health for the Shipley district.

ELLERY TURNER, M.R.C.S.Eng.

We regret to record the death of Mr. Ellery Turner, formerly practising at Beverley, Yorks, who was found dead in bed at Rowton House, Vauxhall, where he had resided for four years. Mr. Turner graduated M.R.C.S.Eng. in 1865, and was highly esteemed by his patients and friends. He had been in failing health for the past six months.

JAMES MUDGE, M.R.C.S.Eng., L.R.C.P.Ed., L.S.A.

The sudden death of Dr. J. Mudge, in Marazion, last week, has caused great regret in the neighbourhood. Deceased was well known, and, being of a genial disposition, his company was much sought after by a large circle of friends. He was medical officer of health, public vaccinator, and medical officer to the eastern portion of Penzance Union. He graduated L.R.C.P.Ed. and M.R.C.S.Eng. in 1879, and commenced practice at Marazion about twenty-five years ago, where he had a large private practice, and was considered very skilful in his profession. Deceased, who was a native of Hayle, where he has two brothers in practice, was 47 years of age. Great sympathy is felt for the widow and three children.

DANIEL MURPHY, M.B., B.CH., B.A.O., R.U.I.

THE loss of a genial and much esteemed young doctor of Cork, Mr. Daniel Murphy, has caused sincere regret in that city. He had been in ill health for some time, and spent the winter in Nordrach, where at first he seemed to make some progress towards recovery, but later he found it necessary to return home, where he died after a few days. For several years after graduation in 1893, Dr. Murphy was house-surgeon to the North Cork Fever Hospital, and afterwards became house-surgeon to the North Charitable Infirmary, Cork, for a few years, but on a vacancy occurring in one of the dispensaries of the city he was elected to, and until his death held the post.

WILLIAM DUNCAN, L.F.P.S. GLASG.

WE regret to record the death of Mr. William Duncan who for the past fourteen years has been in practice in Belfast, and died on July 11th after a lingering pulmonary illness. He was only 46 years of age and owing to his skill, genial disposition, and sympathetic nature he enjoyed a large practice among the working classes of Belfast. He leaves a widow and family.

Literature.

ABDOMINAL PAIN. (a)

WE confess to rising from the perusal of Mr. Ernest Maylard's "Abdominal Pain," with a sigh of disappointment. When we took it up, recollections of Hilton, the wise, the suggestive, the inspiring, and of Head, the brilliant, the original, the accurate, made us anticipate a treatise of philosophical breadth and ripe thought. Instead, we find a scrappy, disjointed set of facts, which strike us as having been put together without much reflection. There is little about abdominal pain that is new; and what is old is trite. The author starts out with the intention of helping the proverbial busy doctor in the differential diagnosis of obscure abdominal disease, but his method of procedure—namely, giving tables of the causes of pain occurring at various points, and some hasty remarks on the pains in other parts of the book, will not, we fear, be of much assistance to the bulk of practitioners. Mr. Maylard never comes to close quarters with his subject; he is for ever skirting round it; every now and again he looks as though he means business, but when it comes to the point he evaporates into banalities Lack of space is a frequent reason given for not dealing thoroughly with a topic, but this reason looks uncommonly like an excuse in face of the fact that the last third of the book is taken up, not with abdominal pain at all, but with directions and hints on the technique of laparotomy. It is difficult to see why these chapters were introduced at all. They have a value as the embodiment of the ideas of a practical operator, but they cannot be said to be apposite. We note with pleasure that Mr. Maylard has the courage to record a case of penumonia in which he was led to open the abdomen under the impression that the trouble was situated below the diaphragm; the mistake is not infrequently made in these days of early operation, but most of the surgeons and physicians concerned prefer to record other evidences of their perspicacity. Another point on which Dr. Maylard's experience is useful is in the definite citation of a case in which a calculus in one kidney caused pain in the opposite loin; this possibility has been denied, but Mr. Maylard's case furnishes demonstrative evidence. Those who do not possess diagrams of Head's areas will be glad to find excellent plates reproduced in this volume, and, indeed, the whole printing and get-up of the book are uniformly creditable We wish we could say the same of the literary style. Infinitives are split in ruthless fashion, and many sentences show marked lack of skill. Thus, page 36, "Such a consideration also tends to bridge the gap or unite together, what, on one side may be regarded," &c., and again, page 45, "Thus any portion of the alimentary tract, when incapable from stricture or other obstructing cause of normally passing on the contents of one section of the canal into another, begins to distend on the proximal side; and by exciting renewed and increasingly more vigorous efforts at muscular contraction, causes pain." To students who are making their first acquaintance with the mysteries of abdominal disease this book may be acceptable.

HERSCHELL ON ELECTRICAL METHODS FOR STOMACH. (a)

THIS little work sets forth the author's experience in a domain which he has made especially his own. Recent electrical developments have greatly increased the therapeutic power of applied electrical currents. It is hard to imagine any more brilliant achievement in practical medicine than the cures obtained in dilatation of the stomach. Those who wish to find an eminently clear account of the methods to be adopted in the electrical treatment of various affections will do well to consult this excellent little volume. Clearly if the theories as to the causation of functional gastric disorder hold good, it should be capable of receiving benefit from electrical treatment. The chapter on gastric neurasthenia or nervous indigestion connotes a catholic education, so to speak, in all branches of medical knowledge. The general practitioner will do well to make himself acquainted with the *role* of modern electrical therapeutics in constipation due to intestinal atony, and in other atonic, neurasthenic, and myasthenic disorders of digestion. Dr. Herschell has made a modest but sound addition to the understandigd of a progressive subject.

Medical News.

Society for Relief of Widows and Orphans of Medical Men.

AT the Quarterly Court of Directors, held on Wednesday, Mr. Christopher Heath, President, in the chair, the Secretary reported that one death and one resignation had occurred among the members since the last meeting. The death of a widow was mentioned who had been an annuitant of the Society since 1886, and had received in grants the sum of £1,063 5s.; her husband had paid £52 10s. in subscriptions. An application for relief had been received from a widow of a deceased member, and a grant at the rate of £50 per annum was voted. Fifty-three widows and thirty-six orphans are now in receipt of relief, the total sum for the half-yearly grants being £1,324. Three new members were elected. The Secretary reported that during the past three months, fifteen letters had been received from widows of medical men, soliciting grants, and relief had to be refused in every case, owing to the fact that their late husbands had not been members of the Society. The annual election of the Secretary took place, and Mr. Edward J. Blackett was appointed to the post.

Deaths From Plague in India.

DURING the weeks ending June 17th and 24th, the deaths from plague in India numbered respectively 4,883 and 4,563. The principal figures were: Bombay City, 151 and 135; Bombay Districts, 238 and 255;

(a) "Abdominal Pain: its Causes and Clinical Significance." By A. Ernest Maylard, M.B., B.S.Lond., Surgeon to the Victoria Infirmary, Glasgow, &c. London: J. and A. Churchill. 1905. 7s. 6d net.

(a). "Electrical Methods in the Treatment of Affections of the Stomach and Intestines." By George Herschell, M.D.Lond. Physician, Welbeck Street Hospital for Nervous Diseases, &c. London: A. Siegle, 1905.

Calcutta, 52 and 37; Bengal Districts, 289 and 162; North-West Provinces and Oudh, 396 and 151; Punjab 3,389 and 3,663; Rajputana, 285 and 82; Kashmir, 3 and 11; Mysore, 23 and 23; Madras Districts, 6 and 3; Burmah, 82 and 93. From the shores of the Persian Gulf and Bahrein Island deaths from plague are also reported.

Cancer Death Rate.

ACCORDING to the report of Dr. James B. Wilkinson, which was laid before the Huntingdonshire County Council, this particular county has, if not actually the highest death-rate from cancer of any county in England, a rate which closely approximates to it.

The Medical Act 1886) Amendment Bill was read for the third time last week. The Bill is intended to carry out the principle of reciprocity between the mother country and Canada in the matter of medical education. During the war in South Africa a number of medical men volunteered to serve with the Army, but the War Office said it was contrary to our law for them to attend a British soldier or to hold a British appointment. This Bill would enable these doctors to enter the service of this country as if they had been born here.

Grave Charge against a Medical Man.

THE Director of Public Prosecutions has intimated that he will take up the prosecution of Dr. Brooks and Arthur Stanton Price, chemist, of Cardiff, who are committed for trial at the assizes at Swansea next week on a charge of attempting to procure abortion.

PASS LISTS.

University of Aberdeen.

AT the Graduation ceremonial last week, the following candidates, having passed the necessary examinations, received the Degree of Doctor of Medicine (M.D.) William Johnston Dewar, M.B., C.M., Francis Grice Jones, M.B., C.M. (Commendation for Thesis), George Grant Macdonald, M.A., M.B., Ch.B. (Honours for Thesis), J. Thornton Macpherson, M.B., C.M., John S. Milne, M.A., M.B., Ch.B. (Highest Honours for Thesis), George Mitchell, M.B., Ch.B. (Honours for Thesis), Herbert Leith Murray, M.B., Ch.B. (Commendation for Thesis), Alex. Charles Profeit, M.B., C.M., Alex. Christie Reid, M.A., M.B., Ch.B., B.Sc.

Degree of Master of Surgery (Ch.M.), John Alex. Mackenzie, M.A., M.B., Ch.B. (Honours for Thesis).

Pass List for Degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.), (New Ordinances).—James M. Adams, M.A., William Campbell, Alexander Donaldson, Robert R. Duncan, Richard Eager, Francis W. Falconer, William M. Fergusson, George J. Forgie, Reginald A. Forster, George Hall, M.A., Alexander W. Laing, James McIntosh, James Mackenzie, Kenneth Mackinnon, George Milne, John A. Milne, Harry R. Neilson, Paul B. Roth, Robert F. Russell, James Silver, F.C., Charles M. Smith, John H. Stephen, I. F. Bernhardi de Villiers, Frederick H. Welsh, Cristina Wilson, Douglas Wood.

NOTE.—Charles Butchart Gerrard has passed all the examinations, but will not graduate until he has attained the necessary age.

The John Murray Medal and Scholarship was awarded to Robert Brown, M.B., Ch.B., Aberdeen.

Diploma in Public Health.—Donald J. G. Johnston, M.B., Ch.B.Aberd., Alexander McRobbie, M.B., Ch.B. Aberd., George A. Ma vor, M.A., M.B., Ch.B.Aberd.

Royal College of Surgeons in Ireland.

FELLOWSHIP EXAMINATION.—The following candidates having passed the necessary examination, have been admitted Fellows of the College:—Mr. J. Campbell, L.R.C.P. & S. I, and Mr. W. J. Mullin, M.B., B.Ch., New Zealand.

Conjoint Examinations in Ireland.

THE following candidates have passed the third professional examination as undernoted—R. Adams, C. Anderson, Miss H. Beamish, R. M. Bronte, W. Carroll, M. E. Cussen, F. Coates, W. J. Deighan, R. Galway, J. Grace, F. M. Hewson, P. M. Keane, G. H. Kinmouth, E. Montgomery, P. Mullany, P. J. McKevett, D. O'Flynn, J. P. O'Kane, H. J. Perry, J. T. Reardon, W. C. T. Robert, and C. Sheehan.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

THE quarterly examinations of the above Board, held in Edinburgh, were concluded on the 18th instant, with the following results:—

First Examination, 4 years' Course.—James Edmund Syme passed this examination.

First Examination, 5 Years' Course.—Of 32 candidates entered, the following 13 passed the examination: F. C. Eberhardt, R. W. A. Brown, S. B. Mehta, Beatrice Coxon, Dora Robbins, K. S. Commissariatwalla, C. J. Lacayo, B. S. Tarapurwalla, J. Paxton, R. F. Lunn, J. Morham, and R. R. Bakshi. Five others passed in Physics, seven in Biology, and two in Chemistry.

Second Examination, 5 Years' Course.—Of 43 candidates entered, the following 24 passed: G. H. Urquhart, K. S. Commissariatwalla, M. B. Patel, C. Berry, A. E. James, N. Walshe-Davidson, E. Eccles, J. H. Bennett, R. E. Laurent, R. G. Sherlock, Effie J Cassels, H. G. Ramsbottom, O. Carlyle, R. B. M. Sullivan, C. C. Campbell, Maria S. Allen, E. S. Shach, A. Johnstone Brown (with distinction), Marguerite A. C. Douglas J. B. Kelso, E. Gibson, W. R. Waddell, C. A. O'Driscoll, and T. B. Johnstone. Two others passed in Anatomy, and three in Physiology.

Third Examination, 5 Years' Course.—Of 29 candidates entered, the following 20 passed: S. I. Hasan H. C. Orrin, J. H. Simpson, H. J. Corrie, Ada C. Boylette, H. F. Shepherd, R. K. Nisbet, T. D. Murison, H. D. Stewart, A. Rae, G. E. Anderson, G. E. Nash, A. M. Davie, H. H. Babington, J. S. Ward, Ethel A. Orchard, Nathaniel Moxon, R. F. C. H. Buchanan, Charlotte E. Pring, and Constance Colley. One other passed in Pathology.

Final Examination.—Of 51 candidates entered, the following 24 passed, and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P.S.G.:—R. M. Fraser, Edinburgh; Mary C. Hamilton, London; G. A. S. Hamilton, Dublin, L. L. Carlos, Cochin, India; R. Wearing, Accrington; A. F. Demary, Canada; Tom N. Darling, Reading; H. A. Bray, Canada; J. N. G. W. McMorris, St. John's, N.F.; J. W. Pell, London; J. K. Lindsay, Edinburgh; E. P. Haythornthwaite, Cumberland; A. L. Pereira, Colombo; G. W. Barber, Ontario; J. W. Wigham, Toronto; C. Chaves, India; E. F. Nyhan, co. Cork; A. S. Donaldson, Canada; Albert E. Tanner, Calicut; P. De Mello, Bombay; J. J. Matheson, Ontario; J. S. Farries, Dumfriesshire; J. R. Purcell, co. Meath; and J. W. Skelley, Govan; and three passed in Medicine and Therapeutics, four in Midwifery, and six in Medical Jurisprudence.

Society of Apothecaries of London.

THE following candidates, having passed the necessary examinations, have been granted the L.S.A. diploma of the Society, entitling them to practice medicine, surgery, and midwifery:—V. H. Blake, A. M. Paterson, C. A. K. Renshaw, L. W. Roberts, L. Sells.

THE first congress of the International Society of Surgery will be held in Brussels in September, under the patronage of His Majesty the King of the Belgians.

THE first International Congress of Physical Therapy will be held at Liége from August 12th to 15th, under the patronage of the Belgian Government.

THE Western Hospital for Diseases of the Skin has been awarded a grant by the Committee of the Metropolitan Hospital Sunday Fund.

THE Accidents (Mines and Factories) Bill, a Government Bill, which affected prejudicially the position of Factory Surgeons, was withdrawn last week.

AN examination for the Radcliffe Travelling Fellowship, of the annual value of £200, tenable for three years, will be held in Hilary Term, 1906, at Oxford.

Notices to Correspondents, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," 'Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Marina.—There is no doubt that the ill-regulated haphazard sea-bathing is responsible for a great deal of harm, and we agree that more ought to be known by the laity of conditions in which it may do actual harm. One of the most fruitful cases of fatal acidents is attempting to swim in a rough sea or for a long distance without the practice required to get into proper bodily training.

Dr. F. (Bedford). We do not quite agree with you. In spite of the particularly fatal combination of phthisis and insanity, the results, under open air treatment, have been encouraging, judging from asylum reports. The insanity is probably of toxic origin.

Country Doctor.—(1) The only consolation is that if they live long enough, people who doctor themselves become our best patients. (2) Certainly; the physician who prescribes has a right to prosecute any druggist not faithfully dispensing what he orders.

Epidemic.—A few years ago New York seldom had a case of cerebro-spinal meningitis notified. In 1903 there we 271, and in 1904 1,211.

Dr. H. (Abergeldy).—Betul-ol, often used for friction in rheumatism is a mentholic acid combined with the methylester of the salicylic radicle. The tree is the *betula lenta*.

E. H. (Croydon).—Statistics show a great diminution in medical students in the U. S. during the past 20 years, but the professors deem this a matter of congratulation, tending to the weeding out of incompetents.

Thermal Doctor.—In many waters which have an indeterminate composition and are well marked for their curative properties, radio-activity has been especially well marked.

Dr. F. (Bombay).—Two serums are potent in plague *if used early* that of Lustig and the Yersin-Roux prepared at the Pasteur Institute Paris.

Infirmary.—In 1904 in London out of a total of 7,654 admissions of alleged lunatics only 3,716 were sent to asylums, and 3,155 discharged within 14 days.

THE DOYEN CURE FOR CANCER.

A facetious correspondent is answerable for the following:—

"The London doctors are enjoyin'
The great defeat of Dr. Doyen,
Who very likely felt 'kock-sure'
That he had found the Cancer Cure,
The 'Micrococci-neoformans'
Played the last act in that performance.
The boasted 'serum' failed to answer
Good-bye to Doyen's cure for cancer."

Mr. W. Watson.—The reduction referred to is due to the absence of epidemic diseases, which usually recur with the advent of the fruit season. There is a singular absence of deaths from diarrhœa so far, and there was not a single death from small-pox reported from any part of the United Kingdom last week.

H. R. H.—Your newsagent correctly reported to you that the numbers of this journal containing Prof. Taylor's articles on "The Diminishing Birth-rate" are out of print. We understand, however, that they have been reprinted in pamphlet form, and are still obtainable of the publishers, Messrs. Bailliere, Tindall and Co.

Enquirer (Waterford).—We believe we are right in stating that the medical officer of a poor-law or of a voluntary medical charity is not entitled to demand a fee for giving evidence upon the death of a patient dying in the particular institution to which he is attached. If, as sometimes happens, a patient is brought dead to a voluntary hospital the resident medical officer gets a guinea for giving evidence and a guinea for post-mortem if necessary. As a general rule, the poor-law medical resident officer is forced by the Guardians at the time of his election to contract himself out of fees that he might otherwise gain for giving evidence as to deaths occurring outside his institution. This contract is grossly illegal. The Medical Defence Union is the only body we know likely to remedy the injustice. The General Medical Council defend nobody.

Vacancies.

The Victoria University of Manchester.—Junior Demonstrator in Physiology. Salary £100 per annum. Applications to the Registrar.

The Royal National Hospital for Consumption, Ventnor.—Senior Resident Medical Officer. Salary £200 per annum, with board and lodging in the Hospital. Applications to the Secretary, 34 Craven Street, Charing Cross, London.

University of Leeds.—Faculty of Medicine.—Demonstrator of Bacteriology. Salary £150 per annum. Applications to the Registrar of the University.

Carlisle Non-Provident Dispensary.—Resident Medical Officer. Salary £150 per annum, with apartments. Applications to the Honorary Secretary, Mr. G. A. Lightfoot, 23 Lowther Street, Carlisle.

Cheshire County Asylum, Macclesfield.—Junior Assistant Medical Officer. Salary £140 per annum, with apartments, board, and washing. Applications to the Medical Superintendent.

Roxburgh District Asylum, Melrose, N.B.—Assistant Medical Officer. Salary £140 per annum, with board, rooms, &c. Applications to Medical Superintendent.

Metropolitan Asylums Board, the Fever and Small-pox Hospitals.—Male Assistant Medical Officers. Salary £180 per annum, with board, lodging, attendance, and washing. Applications to the Clerk, Metropolitan Asylums Board, Embankment, London, E.C.

Bath Royal United Hospital.—Resident Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to J. M. Sheppard, F.C.I.S., Secretary.

Royal Lancaster Infirmary.—House Surgeon. Salary £100 per annum, with residence, board, attendance and washing. Applications to the Secretary.

Ramsgate General Hospital and the Ramsgate and St. Lawrence Dispensary.—Resident Medical Officer. Salary £100 per annum, with furnished apartments, board, and attendance. Applications to H. W. Thornton, Secretary, Dispensary, Broad Street, Ramsgate.

Aston Union.—Resident Assistant Medical Officer. Salary £110 per annum, with furnished apartments, rations, and washing. Applications to John North, Clerk to the Guardians, Union Offices, Vauxhall Road, Birmingham.

British Hospital, Buenos Aires.—House Surgeon. Salary £200 per annum, with board, lodging, wine allowance, &c. Applications to Messrs. Arnold and Sons, 31 West Smithfield, London, E.C.

Lancashire County Asylum, Winwick, Warrington.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Appointments.

Bell, W. Blair, M.D., B.S.Lond., M.R.C.S.Eng., Assistant Gynæcological Surgeon to the Royal Infirmary, Liverpool.

Bulleid, Edgar G., M.D., Clinical Assistant to the Chelsea Hospital for Women.

Coombs, Carey, M.D., B.S.Lond., Honorary Physician to Out-patients Royal Hospital for Sick Children and Women, Bristol.

Daniel, Peter L., F.R.C.S.Eng., L.R.C.P.Lond., Assistant Surgeon to Charing Cross Hospital.

Eason, H. L., M.D., M.S.Lond., Assistant Ophthalmic Surgeon to Guy's Hospital.

Hall, Octavius, L.R.C.P. & S.Edin., L.F.P.S.Glasg., D.P.H.R.C.P.S.Irel., Medical Officer of Health of Devonport.

Rutherford, V. H., M.A., M.B.Cantab., Medical Officer to the Electrical Light and X-Ray Department, St. John's Hospital for Diseases of the Skin.

Saulter, W. W., M.D., C.M., Clinical Assistant to the Chelsea Hospital for Women.

Births.

Newington.—On July 18th, at The Croft, Edenbridge, Kent, the wife of C. W. H. Newington, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

Balfour—Spencer.—On July 20th, at the Parish Church, Winsham, Somerset, Archibald Craig Balfour, L.R.C.P. & S.E., of Carr Bridge, Inverness-shire, son of the late George William Balfour, M.D. of Edinburgh, to Margaret Ellen, daughter of the Rev. D. H. Spencer, M.A., Vicar of Winsham.

Foulkes—Fischer.—On July 20th, at Portsea Parish Church, Captain Thomas Howard Foulkes, F.R.C.S., Indian Medical Service, second son of the late Rev. T. Foulkes, of Salem, to Bertha, second daughter of Colonel Bowness Fischer, late Indian Staff Corps.

Knaggs—Stilwell.—On July 18th, at the Parish Church, Hillingdon, Brevet-Major M. H. Knaggs, North Staffordshire Regt., son of Lt.-Col. Knaggs, to Constance Mary, youngest daughter of Dr. and Mrs. Stilwell, Moorcroft, Hillingdon.

Law—Clay.—On July 18th, at St. John the Baptist's, Broad Clyst, Devon, Horace Law, M.D., eldest son of the late T. Pakenham Law, K.C., to Sybil M. Clay, daughter of the late Sir George Clay, Bart., and Mrs. Holbech, of Farnborough.

Deaths.

Cole.—On July 19th, at 12 Marlborough Buildings, Bath, Fanny, widow of the late Thomas Cole, M.D., F.R.C.P.Lond., of Bath, and daughter of the late Richard Gibson Davey, J.P., of Walmer, Kent.

Lane.—On July 21st, at 9 Gloucester Street, S.W., Rosa Mary, widow of the late Deputy Surgeon-General W. R. Lane, formerly Brigade Surgeon, Brigade of Guards, aged 69 years.

Phillips.—On July 8th, at Pyrford Croft, near Woking, Surrey, William Page Thomas Phillips, formerly of The Grange and The Cedars, Melton, Suffolk, M.A.Oxon., J.P., D.L., barrister-at-law, only child of the late Benjamin Phillips, F.R.S., F.R.C.S., and Elizabeth (née Page), in his 72nd year.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, AUGUST 2, 1905. No. 5.

Original Communications.

AN IMPROVED METHOD OF VENTRO-SUSPENSION OF THE UTERUS. (*a*)

By R. CHARLES B. MAUNSELL, M.B., F.R.C.S.I.,

Member of the Council of the Royal College of Surgeons, Ireland; Surgeon to Mercer's Hospital, Dublin.

In bringing before you the following description of what I consider an improved method of ventro-suspension of the uterus, I will not enter into a lengthy discussion of the merits or demerits of operative treatment of uterine displacements, or of the various operations which have been performed, but I must briefly state my present position with regard to both these matters.

Many uterine displacements can be efficiently treated by one skilled in the application of pessaries, if the patients can be kept under observation for a considerable time. Many hospital patients and most patients sent from country districts require a shorter and more certain method of treatment. In neurotic individuals it appears to me to be better in many cases to perform an operation rather than submit them to repeated vaginal manipulations. Retroflexions require operation much more often than retroversions. When the lower abdomen has been opened for some other reason, it would appear best to remedy any retro-deviation before completing the operation.

With regard to the choice of operation—I have never performed vaginal fixation. Opinions, both written and spoken, of many obstetric authorities lead me to consider that parturition is more likely to be without accident following an abdominal rather than a vaginal fixation.

The Alexander operation is physiologically ideal, but pathology frequently negatives its accomplishment or mars its result. My opinion is that utero-fixation or utero-suspension, by the method to be described, will prove best in patients in whom pregnancy is not likely to follow. In those in whom pregnancy is likely or desirable either the Alexander operation or the following operation should give good results:—

Operation.—The abdominal wall having been divided, either by a vertical incision or by Pfannensteil's transverse method, the peritoneum is incised either vertically or transversely according to whether complications are expected or not. The fundus of the uterus is grasped by a vulsellum and drawn forwards and downwards (see Fig. I).

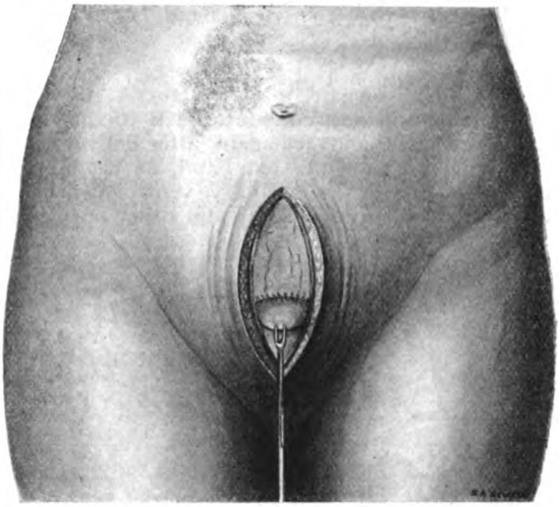

FIG. I.

If the peritoneum has been incised vertically it is closed with a continuous fine silk suture as far as the protruding uterus, so that the uterus protrudes through a transverse slit, as in the alternative method of opening the peritoneum. The edges of the transverse peritoneal opening are united to the uterine wall by a continuous suture of fine silk. On the posterior surface of the uterus the line of suture should lie about three-quarters of an inch from the fundus and on the anterior surface about half an inch from the same point. Whilst the anterior suture is being introduced the uterus is drawn upwards by means of the vulsellum (see Fig. II.). The vulsellum is removed and the uterus falls back towards the pelvis, drawing the peritoneum into a narrow funnel-shaped depression (see Fig. III.), the sides of which can be readily approximated by a few sutures passed from side to side through the fascia and subperitoneal tissue, thus obliterating any dead space and preventing immediate contact of the uterus and abdominal muscles.

The abdominal incision is closed by continuous silk suture for the aponeurosis and subcuticular suture of silkworm gut for the skin. The advantages claimed for this operation are: (1) Firm support for the uterus without interfering with its

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(*a*) Read before the British Gynæcological Society, July 13th, 1905.

mobility; (2) no interference with distension of the bladder; (3) should pregnancy ensue, the peritoneum will accommodate itself to the rising uterus and will contract again after delivery, not remaining as an elongated band, as the fibrous adhesions do in the ordinary ventro-suspension advocated by Howard Kelly and other operators.

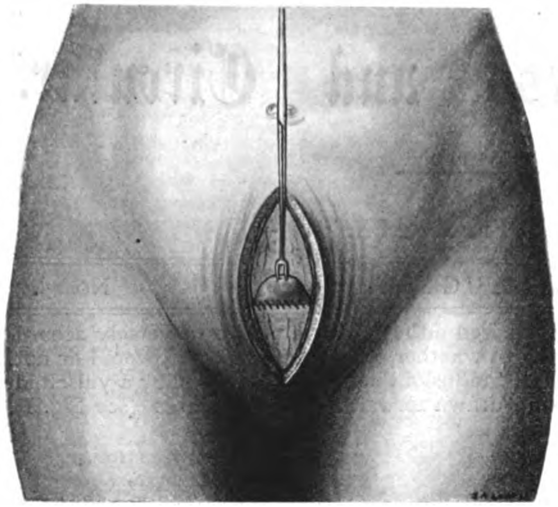

FIG. II.

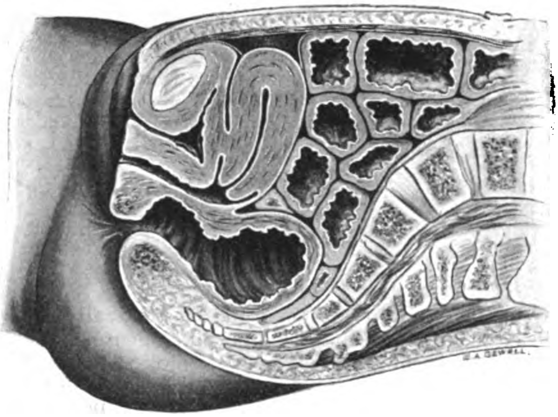

FIG. III.

The third claim is at present merely theoretical as the first of my patients was operated upon not longer than six months ago. The first and second claims are substantiated as fully as five patients, upon whom the operation has been performed, can substantiate them.

Introductory Lecture
ON
ANÆSTHETICS
WITH HISTORICAL SKETCH.

By THOMAS D. LUKE, M.B., F.R.C.S.EDIN.,

Lecturer on Anæsthetics, University of Edinburgh.

GENTLEMEN,—The chief aims of the medical profession have been well defined as—

(1) The relief of pain; and (2) the prolongation of life.

Naturally the first-named will make for the second. One of the most common methods of relieving or preventing pain is the administration of a general anæsthetic. I propose to spend a few evenings of this summer session in explaining to you the theory and practice of anæsthesia, and if you will bear with me and give me your attention, I trust you will think the time not misspent.

Sir Frederic Treves has said with some truth: "The anæsthetist is made, not born like the poet." While quite admitting the fact to a degree, I would like to say that I feel very strongly we have all special bents in life. As some men are good golfers, others brilliant chess players, so in the profession we find one man a born lawyer, others interested in nothing but scientific chemistry. Sir Robert Finlay is a striking instance of an inborn legal bent. He graduated M.D. of this University to please his father, and subsequently took to law—with what result you know. Now, while I know that some of you will take more readily and happily to giving chloroform or ether than some of your fellows, I most distinctly feel there is nothing in the administration of either which any man of ordinary intelligence cannot master with a little application and guidance—you must have practical experience and guidance along with it.

To quote Sir Frederic Treves again, "There is a fairly widespread impression that to give chloroform is a minor act—that the power, if worthy of the name, comes to a man with the granting of his diploma." Men are wont to say, "Well, if a chap can't give chloroform, what can he do?" If you start on methods of your own, uninfluenced by the landmarks afforded by physiology you will fail, and go from bad to worse; if you regard the surgeon's work, keep up a running conversation with the nurse, or allow yourself to drift into a reverie on the law of gravitation, you will also fail.

Every anæsthesia must be undertaken with all seriousness and a sense of individual responsibility on the part of the administrator. The surgeon has his work, often very extensive, cut out for him, and requiring his undivided attention, and be the anæsthetist a student, a house surgeon, practitioner or specialist, he is and must be individually responsible. The very rapidity and ease with which chloroform acts often gives a beginner a false impression. Let him bear in mind he is handling a two-edged sword, and let all his power of observation be concentrated on the thing on hand. We all know that accidents happen with every anæsthetic, and I am afraid some always will happen; a certain percentage is practically unavoidable whatever precautions are taken. But I am quite certain that the larger proportion are avoidable, and are due to bad methods and therefore ignorance, and above all to haste and want of proper sense of the risk incurred. In Sir James Paget's Memoirs, he refers to the lamentable state of mind and remorse which a doctor is reduced to if in one of these emergencies or crucial moments, which come in every man's practice, he fails to succour a patient or do the right thing from ignorance or from not taking advantage of the opportunities of his student days. There can be no better illustration of this than malpraxis in chloroform emergencies. If you lose your head you lose your patient, and if you are in general practice, your local reputation will suffer enormously. A man may forgive you if his wife dies in your hands from difficult labour or even puerperal fever, but if of chloroform, never.

The need for thorough instruction of all aspirants to the medical profession in anæsthetics has so far only been recognised and insisted on by a portion of the Examining Boards and Universities; while it is unfortunately extremely rare for any attempt to be made to test the candidate's knowledge of this subject, even in the qualifying examination.

Year after year men become qualified to practise medicine without even having attended a lecture on the subject or personally administered any anæsthetic. There is no question that to this fact is due a very large number of the fatalities which annually occur under the nfluence of narcotic vapours.

(a) A Lecture given at the Royal Infirmary, Edinburgh, on May 4th, 1905.

What is a general anæsthetic ?

It is a substance which has the power of destroying conscious sensibility throughout the organism—but most anodynes, narcotics, and soporifics, given in sufficient doses effect this. Accordingly such a definition is scarcely complete.

We require the following properties in a general anæsthetic :—

1. It must be able to produce general loss of sensation.
2. It must be of such a nature as to be capable of being readily introduced into the circulation without any considerable degree of discomfort to the patient.
3. It must produce its effects gradually and progressively, and so be readily under the control of the administrator.
4. It must bring about not only general sensory paralysis but such a loss of motor power as to render the performance of surgical operations practicable.
5. Its action on the sensory and motor systems must not be associated with greater excitement, convulsive movement, or any interference with respiration, circulation, or any other important vital processes than can be readily controlled by the anæsthetist.
6. Finally, it is a *sine quâ non* that the agent employed shall be of such a nature that when it is withdrawn the whole organism will resume its functions, and return to that condition in which it existed when the anæsthetic was first applied.

The agents known to best fulfil such conditions are nitrous oxide, ether, chloroform, chloride and bromide of ethyl.

General surgical anæsthesia may be defined as a state of profound insensibility, brought about by the action of a general anæsthetic, and of such a character as to allow of the performance of any surgical operation painlessly.

Ancient Methods of Producing Anæsthesia.

We are unable to trace any evidence of the most rudimentary knowledge of true anæsthetics such as we now use further back than the dawn of the last century, but we find it was customary to endeavour to allay the pain of operative procedure by the internal administration of drugs in ancient days.

We can in the very earliest writings of the ancients find allusions to the use of *Mandragora*—or mandrake, a plant allied to belladonna or deadly nightshade. A wine of mandragora was used by the Romans to relieve the sufferings of the crucified, and it is maintained by the divines that it was either this preparation or one of Indian hemp which constituted the "vinegar on a sponge offered to our Saviour on the Cross."

Pliny speaks of mandragora as follows : "If anyone eat of it he will immediately die, unless he be treated with butter and honey, and vomit quickly." Further, if anyone is to have a member mutilated, burnt or sawn off, "let him drink half an ounce with wine, and let him sleep until the member is cut away without pain or sensation." Dioscorides, speaking of the plant, also says : "Medical men use it when they have to resort to cutting or burning." The late Sir Benjamin Ward Richardson, after a lapse of many centuries obtained a fine specimen of mandragora root, and after making wine from it, and testing it, found it was a narcotic having precisely the properties which the ancients ascribed to it.

Indian Hemp : "Bhang or "Gunyah." There seems to be no manner of doubt that this still highly valued drug was from the earliest days used for pain-killing purposes. Some years ago an old Chinese manuscript was laid before the French Academy by M. Julien, in which the use of Indian hemp for annulling pain in surgical operations is mentioned as having been resorted to by a medical practitioner named Hoa-tho as early as the third century, 300 A.D. A preparation of this drug is what is probably referred to by the prophet Amos, 700 B.C. as "the wine of the condemned." In most Eastern countries it has been used extensively by criminals condemned to suffer torture.

Opium was employed in later years to dull the senses of the patient prior to operation, and Mr. Annandale tells me that even so recently as his student days he remembers the administrations of laudanum and whisky before chlorform came into such general use in Scotland.

In 1784 a certain Dr. Moore proposed to bring about local anæsthesia of limbs during surgical operations by compressing the nerves supplying them. He tried this method in a case in Dr. Hunter's practice, and applied a tourniquet for an hour before operation, to compress the nerves, with, however, partial success. Malgaigne also tried this method but necessarily without much success, for the compression of the nerves themselves causes considerable pain, as any of you who have seen an aneurysm treated by compression will realise—and further the prolonged application of compression naturally will cause vascular stasis and tendency to gangrene.

Again Morgagni, Hoffman, and others used digital compression of the carotid arteries to diminish the blood supply of the brain and so produce complete or partial anæsthesia. This method undoubtedly produced stupor or coma with remarkable rapidity, and is practically identical with the *modus operandi* in present day "garotting." Further, it is quite commonly used in the East—Burmah, Java, and Sumatra—though scarcely for orthodox purposes.

An officer in the Indian Medical Service wrote to the *British Medical Journal* in August 1902, describing a very interesting exhibition of this mode of producing anæsthesia, of which he had been a witness in 1884 while going from Moulmein to Rangoon on a coasting steamer. The operator was a Burmese juggler from Mandalay, who performed a number of very clever tricks, most of which were quite new to the majority of European passengers. He asked an English officer to order his Madrassy servant to sit down on the deck, and this being done he now told the audience he was going to show them how the dacoits or professional native robbers rendered their victims insensible. His next move was to seat himself in front of the servant, and after telling him not to be afraid he seized his neck with his hand on either side, and with his thumbs firmly compressed the soft parts below the angle of the jaw against the spine. Immediately the man operated on got tremulous and limp, and in a short time fell back on the deck as if in a dead faint. At this stage some of the lady passengers became greatly alarmed, and seeing this the juggler speedily resuscitated the unconscious man by slapping him on the face with a handkerchief. The man rose from the deck and walked off, though with a somewhat unsteady gait. The unconsciousness was evidently produced by digital compression of the carotids causing temporary cerebral anæmia. This method while effectual, is by no means free from risk. Dr. Joseph Bell tells me he tried it experimentally on a friend many years ago, and had some considerable difficulty in bringing him round.

[A short account followed of the discovery of nitrous oxide, at first by Davy, and then its introduction into dental practice by Wells ; of Morton's discovery of the anæsthetic properties of sulphuric ether, and of Simpson's work in introducing chloroform as an anæsthetic agent in Scotland.]

What has anæsthesia done for the world at large, and for the medical profession, in addition to having actually relieved or prevented pain and shock in some millions of cases ? What was the position of the subject in the early days of the discovery, and how does that position compare with the present ? What operations were to the patient in pre-anæsthetic days has been vividly described by one who had himself come under the surgeon's knife in those days. The following are extracts from a remarkable letter written to Simpson by an esteemed professional colleague who holds a distinguished place in British science and literature :—

"Several years ago I was required to prepare on very short warning for the loss of a limb by amputation. A painful disease, which for a time had seemed likely to yield to the remedies employed, suddenly became greatly aggravated, and I was informed by two surgeons of the highest skill, who were consulted on my case, that I must choose between death and the sacrifice of a limb, and that my choice must be promptly made, for my strength was fast sinking under pain, sleeplessness, and exhaustion. I at once agreed to submit to the operation, but asked a week to prepare for it. The week so slow and yet so swift in its passage, at length came to an end, and the morning of the operation arrived. There were no anæsthetics in those days, and I took no préparative stimulant or anodyne of any kind, unless two cups of tea, which, with a fragment of toast, formed my breakfast, be considered such. The operation was a more tedious one than some which involve much greater mutilation. It necessitated cruel cutting through inflamed and morbidly sensitive parts, and could not be despatched by a few swift strokes of the knife. I do not suppose that it was more painful than the majority of severe surgical operations are, but I am not, I believe, mistaken in thinking that it was not less painful, and this is all I wish to contend for.

"Of the agony it occasioned I will say nothing. Suffering so great as I underwent cannot be expressed in words, and thus fortunately cannot be recalled. The particular pangs are now forgotten; but the black whirlwind of emotion, the horror of great darkness, and the sense of desertion by God and man, bordering close upon despair, which swept through my mind and overwhelmed my heart, I can never forget, however gladly I would do so. Only the wish to save others some of my sufferings makes me deliberately recall the anguish and humiliation of such an experience; nor can I find language more sober or familiar than that I have used to express feelings which, happily for us all, are too rare as matters of general experience to have been shaped into household words.

"Further, during the operation, in spite of the pain it occasioned, my senses were preternaturally acute, as I have been told they generally are in patients in such circumstances, I watched all that the surgeons did with a fascinated intensity. I still recall with unwelcome vividness the spreading out of the instruments, the twisting of the tourniquet, the first incision, the fingering of the sawed bone, the sponge pressed on the flap, the tying of the blood-vessels, the stitching of the skin, and the bloody dismembered limb lying on the floor. Those are not pleasant remembrances."

Before the days of anæsthetics a patient preparing for an operation was like a condemned criminal preparing for execution. He counted the days till the appointed day came. He listened for the echo on the street of the surgeon's carriage. He watched for his pull at the door-bell; for his foot on the stairs; for his step in the room, for the production of his dreaded instruments, for his few grave words and his last preparation before beginning. And then surrendered his liberty, and, revolting at the necessity, submitted to be held or bound, and helplessly gave himself up to the cruel knife. The excitement, disquiet and exhaustion thus occasioned could not but greatly aggravate the evil effects of the operation which fell upon a physical frame predisposed to magnify, not to repel, its severity.

In Sir James Paget's "Reminiscences," he refers to the horror occasioned to his wife and her guests at afternoon tea-parties by the screams and cries of the victims of the operating knife in the theatre which was adjoining to their residence in Bartholomew's Hospital.

Why do not deaths from anæsthetics show signs of diminution? During the last ten years there have been double the number of deaths in this country of the preceding decade, which is clearly out of proportion to the increased use of anæsthetics. In 1897 alone there were no less than 95 recorded deaths. How many unrecorded we do not know. The reason chloroform is far too frequently chosen as the anæsthetic when safer agents, such as N_2O and ether, should be used is that the responsibilities involved in administering anæsthetics are not yet fully realised. The administration is too often placed in the hands of comparatively unskilled men; and further, the natural tendency possessed by patients under anæsthetics to become the subject of obstructive breathing is not yet sufficiently recognised.

It can never be too firmly insisted that the pouring out of a certain quantity of liquid anæsthetic upon a towel or lint and holding near a patient's face does not and never can constitute the safe and skilful administration of an anæsthetic. It is quite possible that a certain number of such cases may, by good fortune, be unattended by any obviously bad result; but a practical knowledge of the varying rhythm displayed by the respiration under nitrous oxide, ether, and chloroform, with the exact import of every change in its character; of the many kinds of obstruction to efficient oxidation which may arise; of the mechanical effect of posture upon the circulation, and the impediments which certain positions of the body present to the free movements of the diaphragm, thorax, and abdomen; the recognition of the absolute necessity for mouth gag, tongue forceps; and even tracheotomy instruments being at hand during every general anæsthesia, for whatever purpose it may be undertaken; these with unremitting attention to the symptoms as they arise, and instant elimination of asphyxial elements are absolutely necessary factors in the making of a skilled administrator.

Mr. Marmaduke Sheild, Surgeon to the London Hospital, has admirably summed up the position of the general practitioner as regards anæsthetics:—"The difficulty suggests itself as to what cases or class of cases it is justifiable for a man of ordinary knowledge and experience to undertake. The answer is obvious—

"In districts remote from large cities, it is the duty of every man bravely to encounter difficult and dangerous cases, and to do his best by them. In other circumstances the rule is widely different."

If medical men were well educated in the theory and practice of anæsthesia, they would recognise for themselves that for nose and throat operations. associated with severe hæmorrhage, for cases where the breathing is embarrassed by aneurysm or tumour, or for prolonged abdominal operations, the administration of the anæsthetic should be entrusted to those who have given more than ordinary time and attention to the subject. The satisfactory administration of anæsthetics in many cases of disease, *e.g.* empyema, is fraught with risk. Safety to the patient and comfort to the operator can only be insured by long experience, caution, and skill. It is quite impossible to suppose that all medical men can be educated to such a high pitch of excellence. They should, however, be enabled during their hospital career to attain a sufficient knowledge to fit them to estimate the limit of their own capabilities, and to know when a given case is difficult or dangerous. If once the young practitioner grasps the fact that every case of anæsthesia is a study in itself, in the selection of the appropriate agent, for safety, and for the operator's convenience, fully appreciating that every case has its peculiar risks and after dangers, he would continue to improve as years advance. At all events, his medical teachers will have done their duty by equipping him as well as possible for one of the most important after duties of his professional life."

THE RAW MEAT TREATMENT OF TUBERCULOSIS.

By GEORGE PETIT, M.D.,

Of the Faculty of Medicine of Paris.

WEISS, of St. Petersburg, was the first to introduce meat as a therapeutical agent, subsequently applied to the treatment of tuberculosis by Fuster, of Montpellier. Richet and Héricourt, having instituted a series of experiments on dogs, concluded that raw mutton, in doses of from six to nine ounces in the twenty four hours, delayed the progress of tuberculosis, and, on the strength of their observations, tuberculous patients were fed on meat-pulp, either pure or mixed with mashed potatoes, lentil flour, sugar, &c. The method, however, did not give any very striking results, and soon the employment of raw meat became limited to the "præ-tuberculous." Moreover, some practitioners allowed it to be lightly grilled, thus rendering it less repulsive to take, while others preferred meat powder. The raw meat treatment of tuberculosis has its ardent partisans,and its not less ardent detractors. It has not become popular, probably because it is so frequently objected to by patients, and also because of the recognised dangers attending the ingestion of uncooked meat.

The general impression appears to be that the physiological data upon which the raw meat treatment was originally introduced were incorrect, an opinion based upon the disappointing results of hyperalimentation. It is even alleged to fatigue digestion and to disturb the organism by increasing the quantity of waste products, toxins, excreta, and fermentations, the increased oxidation thus induced tending to precipitate the wearing out of the organism. Under these circumstances the organism is "consumed," and after a period of apparent improvement the disease takes on a more rapid course.

The disfavour into which the raw meat regimen has fallen is to some extent the consequence of the exaggerated claims advanced by its partisans who wished, to the exclusion of all other kinds of food, to make raw meat the panacea for tuberculosis, a panacea not only infallible, but exclusive.

Dr. Edmond, however, points out that the use of raw meat does not necessarily exclude the administration of other aliments, variety of food being at least as important as quality. Oils, fats, and farinaceous articles act as calorific agents by providing the carbon necessary to combustion which is the fundamental feature of organic life. Fruit, green vegetables, and milk add to the resources at our disposal, although they can only be regarded as accessory. The practitioner's great object must be to awaken the appetite when this is defective, for if we can only get the patient to eat, digest, and assimilate well, we may hope to see the disease arrested. In the contrary event, the chances of recovery are small. The gastric state of the tuberculous renders it impossible to generalise any one method, and the monopolisation of any one therapeutic method strikes one as absurd in the light of our present knowledge.

Foods will be assimilated and utilised the more readily the more easily they are digested. Vegetable albumin is less easily digested than albumin of animal origin, and certain structures—bone, cartilage, and elastic tissue, the flesh of certain animals and fish roe, are with difficulty, if at all, assimilable. Experience has shown that we cannot give an equal volume of vegetable albumin in lieu of animal albumin, for if we do so the patient loses weight. Admitting that it is important to nourish the tuberculous well and fully, there is no necessity for hyperalimentation; in other words, we must stimulate functional activity to assist nutrition without, however, unduly taxing that function. Exaggerated alimentation is not an exchangeable term for hyperalimentation. Superabundant alimentation, when in excess of the requirements of the organism, soon brings about disturbances of nutrition, and is productive of arthritism or obesity. Huchard and many others have insisted on the dangers associated with the raw meat diet which determines hepatic congestion, with dyspepsia, biliary and renal lithiasis, arterial hypertension, and arterial sclerosis. Then, too, the tuberculous subject undergoes the rest cure coincidently with the hyperalimentation, thus creating an unfavourable state of things, a flagrant opposition between clinical observation and therapeutical application. Adipose tissue, says Garnier, is the one that undergoes most marked development when carbohydrates are given, but fats which are less readily assimilated than carbohydrates are also stored up in adipose tissue. When we aim at producing fat we ought to have recourse to fatty fish, vegetable soups, sugar, wine, &c.

Turning, however, to the subject under consideration, viz., the use of raw meat in the treatment of tuberculosis, I will briefly give the results of my personal observations. My patients for the most part had been advised to adopt this regimen, or had done so *proprio motu*.

We must not overlook the fact that we ought to give the organism only such aliments as it can turn to account and the stomach only what it can digest. According to Dujardin-Beaumetz the nourishment of convalescents should, above all, be substantial and reparative, the nitrogenous elements should predominate, but care should be taken to commence the regimen with the most digestible articles, gradually returning to the normal alimentary regimen of the healthy man. Crude aliments, such as meat, milk, eggs, &c., are not always suitable for a nitrogenous regimen by reason of the insufficiency of gastric juice obtained in many maladies and in convalescents. The integrity of the gastric secretion is obviously highly important in respect of digestion and especially of assimilation, and in tuberculosis this integrity of function is almost always more or less in default. Dr. A. Robin, having examined the gastric juice in eighty-five tuberculous patients at various stages of the disease, found, in the first period, gastric hyperæsthesia with excess of acid, the total acid being increased. To these initial secretory troubles succeeds a deficiency of solid acid, and we get chronic gastritis in the cavernous stage, characterised by atrophy of the gastric glands, which are strangled by the overgrowth of the connective tissue. In the course of chronic pulmonary tuberculosis it is possible to observe a sort of gastric cycle beginning with stimulation of the function, and culminating in total abolition of the function. These modifications of secretion are directly related to disturbances of blood pressure, and may perhaps explain the frequency of hæmoptysis of alimentary origin in tuberculous patients, described by Dr. Sabourin. Patients who are ordered hyperalimentation have only one thing in view, *viz.*, to gorge themselves with red, roast, grilled, underdone or raw meat, to the exclusion of other articles of food, and in certain of these patients we witness recurrent attacks of hæmoptysis. These attacks of hæmoptysis occur without apparent cause, and recur even while the patient's general condition seems to be improving. The hæmoptysis often ceases on a change of diet. Then, after a few days' rest, the patient resumes his tonic alimentation and sooner or later the bleeding is repeated. In hæmoptysis of alimentary origin one observes temporary cloudiness of the urine preceding the hæmoptysic crisis by a few days, and persisting so long as the latter lasts, should no change of diet intervene. This urinary phenomenon is a sign of the greatest importance, for it is the outward and visible manifestation of the "surfeit" of the organism.

I had long observed these various phenomena, and I endeavoured to ascertain their cause. I noticed that under the influence of a raw meat diet marked phosphaturia was produced, with an increase in the excretion of urea, almost always coinciding with hyperacidity of the urine; moreover, the greater the hyperalimentation the greater the fall in urinary acidity. My observations therefore, seem to show that the raw meat diet gives results just the opposite to those aimed at, in other words, that "the more the tuberculous patient overfeeds the greater is his denutrition." These facts confirm the results obtained by Dr. Robin in respect of the demineralisation of the organism in those predisposed to tuberculosis, whence the necessity of combating this demineralisation in the præ-tuberculous and in the tuberculous during the first and second periods of the disease. In all probability this demineralisation facilitates the invasion of the organism by the tubercle bacillus and creates a *milieu* favourable to its development.

Recent researches have given us clear and precise ideas in regard to disturbances of nutrition. We know that if any one of the principal functions of the economy, such as the nervous system, digestion or respiration, gets out of order, the organism as a whole is thrown out of gear. There is a leakage of organic salts, the very salts that form an integral constituent of the cells, a loss that is manifested in a urological syndrome in which phosphatic waste holds the first place. At the same time the alimentary phosphates and lecithins are incompletely assimilated and nitrogenous metabolism is diminished. These disturbances of the exchanges are very common, and almost invariably accompany diseases of growth, neurasthenia, albuminuria, phthisis and all febrile affections. In order that the ultimate absorption of the aliments shall take place, all the preliminary operations must be duly effected under normal conditions, each organ must have contributed its quota of work and special secretion on the passage of the alimentary products.

When this is not the case, when the aliments in their passage through the organism meet with diseased organs which do not provide, or only in part, their share of work and special elements, the multiple operations which, together, constitute digestion, are badly and incompletely performed and the aliments arrive incompletely transformed, and in a state ill-suited for absorption. That is so much lost to nutrition, and so much material to undergo fermentation, and consequently to become injurious instead of of being useful.

Dr. Doléris maintains that the abuse of nitrogenous food is the cause of nearly all the diseases of nutrition. He regards "albuminism" as more dangerous than alcoholism, for only the drinker makes an abusive use of alcohol, and he is perfectly aware that he is doing wrong, while in respect of albumin, most human beings indulge therein in good faith, convinced that they are thereby increasing their strength and averting starvation of their tissues. It is obvious, then, that no general rule can be laid down for the alimentation of the tuberculous in whom, for the most part, the digestive organs are so weakened as only to allow of very moderate nourishment.

This is one of the strongest arguments against forced alimentation, the abuse whereof even in healthy individuals, is contrary to the elementary laws of personal hygiene. This is more than enough to condemn forced alimentation, which is capable *per se* of determining a morbid state *à fortiori* of aggravating pre-existing disease.

In health, says Dr. Blanc, the vital expenditure is compensated by the equivalent of daily nourishment, but when disease supervenes there is a more or less pronounced increase in the expenditure. To the waste produced by the outgoings we oppose a superabundance of intake, in the form of forced alimentation, but we have to ask ourselves, what is the value of this intensive nutrition as applied to animals?

In animals subjected to the fattening process the mortality is from 15 to 20 per cent., and when the object has been attained, when they are "ripe" for the table, few among them could withstand many more days of the special regimen. No doubt in certain cases the method has given beneficial results in human beings, but it is none the less recognised by experienced observers that the results are usually negative, when not actually injurious by precipitating the fatal termination in patients who, but for the regimen, would have survived for a time longer. Gastro-enteritis, hepatic hypertrophy, renal inflammation, nervous disturbances and cutaneous troubles are common results of this process, and when patients tolerate it there is almost always excessive production of urates. It is a matter of common knowledge that incomplete combustion of the aliments is one of the great causes of gravel, obesity, diabetes, and other formidable complications.

It should be remarked *en passant* that we are not dealing with hyperalimentation by ordinary foods, that is to say, foods to which the organism is accustomed, but of raw meat, which is quite a novel diet. Under these conditions, denutrition takes place much more rapidly, as is evidenced by the phosphaturia constantly observed in persons subjected to the raw meat diet.

Dr. F. X. Gouraud, having given special attention to phosphatic exchanges in normal and in diseased organisms, says: "Certain suspicious-looking specimens of urine, cloudy, it may be, owe their appearance to the presence of phosphates in suspension. It does not follow that there is phosphaturia—*i.e.* excess of phosphates in the urine; under certain conditions the phosphates are spontaneously precipitated, even though present in normal proportions. That happens when the urine, instead of being acid, is alkaline, simply because certain phosphates are but feebly soluble in alkaline media. It also occurs when phosphates, without being in excess, are present mostly in the form of earthy phosphates (phosphate of lime), because these are but slightly soluble, much less so than the alkaline phosphates (of soda). Consequently, just as the spontaneous precipitation of uric acid in no wise implies a real excess of the acid so the spontaneous precipitation of phosphates does not necessarily imply an excess thereof. Chemical examination, therefore, alone enables us to prove the existence of phosphaturia or hypophosphaturia. The phosphaturia in question is ephemeral. True, protracted phosphaturia is more particularly associated with the following pathological states: dyspepsia, tuberculosis, diabetes, and neurasthenia. In such cases phosphaturia is of primary importance as a guide to diagnosis, prognosis, and treatment.

Moreover, it has always seemed to me that the hypoacidity consequent upon hyperalimentation by raw meat was specially well-marked in tuberculous subjects, still possessed of a certain consistency of the tissues, those sufficiently well provided with adipose tissue to pass for fat. In thin tuberculous patients the raw meat regimen is followed by a fallacious period of apparent increase of weight, promptly followed by physical deterioration due to hyperoxidation of the cells accompanied by marked repulsion for all kinds of food, so that we not only fail in our object, but render subsequent alimentation difficult or impossible. In the same way I have observed in several cases of treatment by raw meat acute attacks of toxæmia simulating acute tuberculosis, in which improvement followed cessation of the regimen and its substitution by milk. As soon as the organism has recovered itself I put these patients on a milk-vegetable diet. Well-cooked bread is an excellent food for the tuberculous; the crust contains 13 per cent. of nitrogenous matter and 67 per cent. of starch, and is rich in nuclein and phosphated principles. Leguminous flours, diastased or not, are equally useful in making good the loss of phosphates, nitrogen and carbon, which is exhausting the patient (Gautier). Herbaceous vegetables have the advantage of overcoming constipation, and they introduce iron as well as lime and magnesia. Feculents rich in nitrogen, peas, lentils, haricots, and alimentary pastes, are useful adjuvants of hyperalimentation.

In spite of the willingness of the patient, in spite of a well-thought-out dietary, it often happens that hyperalimentation is impracticable. Dyspeptic disturbances supervene, with fœtid diarrhœa, symptoms of auto-intoxication, and scanty urine, and one is constrained to modify the regimen. In such cases the patient is put on milk, and the question of alimentation has to be reconsidered later on.

Another method for ascertaining the effects of particular regimens is based on the determination of the urinary co-efficients. It consists in making quantitative analyses of the urine and founding one's plan on their relationship in point of proportion. In this way we measure, not the actual intake of alimentary substances, but the quality of the functions. The most useful data are the following:—(1) The proportion of nitrogen excreted in the form of urea compared with the total nitrogenous output; (2) the proportion of total carbon output compared with the total nitrogenous output; (3) of the weight of urea compared with that of the total fixed matters; (4) of uric acid to urea; and (5) of the mineral constituents of the urine to the total of fixed matters.

I do not wish, however, to insist on the toxic phenomena that may follow the abuse of raw meat, since these are familiar to all. I will simply draw attention to the diminution of the total acidity, and of phosphoric acid in particular, in contrast with the exaggerated excretion of urea without any notable change in the total quantity of urine.

According to Dr. Maurel, 4·055 gr. of phosphoric acid per kilogramme is sufficient for the organism under ordinary conditions of wear and tear, and this quantity is contained in the ordinary diet. The quantity of acid eliminated in the urine rarely falls below 1 gramme, equal to 0·016 gr. per kilo., even if the quantity in the food be much reduced. It is necessary to bear this clearly in mind in seeking to explain the conditions under which the normal figures are modified. In the elements of the tissues phosphorus exists in combination with the proteid constituents of protoplasm, and, like the latter, undergoes an oxidising process which throws it out in the course of disassimilation. The daily loss from the wear and tear of the tissues, *i.e.* the oxidation of the organic phosphatic compounds, is represented by about 2·50 gr. of phosphoric acid. This loss is made up by the phosphorus contained in the food, animal and vegetable. In vegetables, as in animals, the parts of the plant in which there is most vitality, the buds and seeds, for example, are richest in phosphorus. It seems much more reasonable, from many points of view, to take the phosphorus of which we stand in need from vegetables. Although man is omnivorous, it is from the vegetable, rather than from the animal, kingdom that man draws the mineral elements necessary to his maintenance. Meat contains them, it is true, but in less quantity, and their utilisation entails greater digestive activity. The vegetable kingdom, by a synthetic process, transforms the phosphorus which it takes from the soil into organic compounds, such transformations being essential to plant-life and growth. Experience shows that the organic compounds formed in plants are admirably adapted to stimulate the phenomena of development in growing animals. Young animals whose growth it is desired to promote are fed on cereals and leguminosæ, with young shoots of the graminacæ in which the organism finds the organic phosphates which stimulate its activity and nutrition. (Petit and Thezard.)

If, then, we take into consideration the fact that phosphoric acid is the element most lacking in the food, and that all other elements are only assimilated in proportion to the quantity of this body present we shall at once grasp the importance of ensuring an adequate supply thereof. Before any other treatment we must make sure of obtaining a certain acidity and a certain degree of phosphatisation. In the absence of this principle no chemical task can be undertaken and no medication can do good. That is the principal cause of the failure of certain methods of treatment which, if successful in some, are unsuccessful in others. The use of raw meat diminishes the acidity and thereby hinders assimilation, and by exaggerating the elimination of urea weakens the resistance of the organism and promotes toxæmia. My conclusion is that in tuberculous subjects the use of raw meat should be strictly prohibited, more particularly in the præ-tuberculous and in tuberculous children, such prohibition admitting of no exception.

Clinical Records.

CASE OF URETHRAL CYST. (a)

By H. MACNAUGHTON-JONES, M.D., M.Ch., F.R.C.S. I. & E.

A PATIENT, æt. 34, a widow, consulted me for pain in the urethra, and frequency of micturition, the bladder having to be relieved every few hours, sometimes oftener, with constant escape of urine at times. The pain was especially severe after urine had been passed. It was intensified during the catamenial period.

On examination, I found a swelling about the size of a walnut occupying two-thirds of the urethral canal, beginning a short distance behind the meatus in the urethro-vaginal septum.

The diagnosis lay between a urethrocele, a diverticulum of the urethra and a cyst. On passing a sound into the urethra, though it could be felt close to the cyst wall, it could not be passed into the sac. The question then arose if the cyst were congenital, a development of such as has been described by Englisch, who found them in the newly-born, and here developed into a larger size in after life; or, secondly, a true urethral diverticulum, in which all the urethral coats are present, a weakness occurring at some one joint, as described by Lannelongue and Priestly; or, thirdly, a dilatation of a lacuna of Morgagni, the result of inflammation with closure of its orifice and subsequent dilatation, as described by Winckel. The position of the sac was against its being due to dilatation and occlusion of Skene's tubules.

On re-examination at the operation under an anæsthetic, I came to the conclusion that it was a cyst. Mr. Targett, who was present, agreed. On isolating the cyst wall, characteristic cystic fluid escaped. I worked round the sac, hoping to separate it completely from the urethral mucous membrane. This, however, I found to be impossible, as the deep portion of the sac consisted of the dilated urethral wall, and this was removed in extirpating the cyst. I had now to make the posterior urethral wall by a plastic operation. This I succeeded in doing, finding sufficient mucous membrane to form the canal, and covering over the vaginal surface with the vaginal membrane. This was done over a stout sound. I inserted a glass catheter, and emptied the bladder of some retained urine. The patient was carried into bed. She was a very stout woman, weighing some 14 stone, and unfortunately, in her removal from the table the catheter was broken, half remaining in the bladder. A rubber catheter was inserted and retained. The following day, under an anæsthetic, I explored the bladder, and found that the broken catheter was lying posteriorly and low down. On the next day I performed suprapubic cystotomy, removed the half of the catheter, found that the two pieces fitted accurately, and closed the wound completely without drainage. It healed by primary union. During the time of healing, the urethral wound had re-opened. I did not interfere with it again until April 3rd, the patient in the meantime having gone to the country to recruit, and though the urethral canal was incomplete for over an inch, the sphincter of the bladder being in no way interfered with, she had much less pain and discomfort than before admission.

On April 3rd, I performed another plastic operation, and this was so far successful that only some three-eighths of an inch of the urethral canal was now exposed. On May 13th, I again operated, and brought the opening to within a quarter of an inch of the meatus. As the patient had now complete control and power of retention with perfect comfort for six hours, I did not interfere again. The case is interesting, both from the histological and the operative point of view. I think that the cyst was undoubtedly one of congenital origin; the urethra forming part of the cyst wall. Should I again meet with a similar case, which is not likely, I should have learned my lesson in remembering this during the dissection. Her own statement of her present condition is as follows:—"I am glad to tell you I am feeling better than I ever did. I can retain my urine quite well five or six hours."

THE tenth International Anti-alcohol Congress will be held at Buda-Pesth from September 11th to 16th. Professor Gruber, of Munich, will deliver an address, entitled "The Hygiene of the Ego."

(a) Read before the British Gynæcological Society, July 13th, 1905.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, JULY 13TH, 1905.

DR. WILLIAM ALEXANDER, President, in the Chair.

Dr. **MAUNSELL** read some notes on an improved method of

VENTRO-SUSPENSION OF THE UTERUS,

which will be found with illustrations on pp. 103-4.

In the discussion which followed

Dr. **MACNAUGHTON-JONES** said that he thought it would be better to restrict the term "ventro-fixation" to those cases where the uterus was fixed to the abdominal wall outside the peritoneal and sub-peritoneal fascia—a method which he considered should only be adopted after the child-bearing period. The term "suspension" it would be better to reserve for Kelly's more recent method, and those operations of an intra-abdominal nature in which the uterus was not fixed, but where traction was exerted through the round ligaments. The Alexander-Adams operation was the ideal operation during the child-bearing period in a free, mobile, and not very large uterus. He thought the abdominal method was always to be preferred where the adnexa were affected or exploration was demanded. In such cases he had for some time been in the habit of performing the following operation, and had hitherto had no case of failure. After the adnexa have been examined, and dealt with according to circumstances, the uterus is brought well forward—and the round ligament of one side is hooked on the finger, a fairly thick gut ligature being passed through the peritoneum and sub-peritoneal fascia. The ligature then takes in the loop of the round ligament. The two ends of the ligature are caught in the forceps, and allowed to drop over the side. The same procedure is carried out on the opposite side. The wound and exposed cavity having been carefully cleansed, the inner end of one of the ligatures is now carried from within out through the peritoneum and sub-peritoneal fascia at the opposite side, and the same is done with the other. The two ligatures thus cross, either holding a loop of the round ligament close to the uterine cornua. The peritoneum is now sewn with cumol gut, and the ligatures holding the round ligaments are tied *en route*, after which the abdominal toilet is completed. If the uterus be exceptionally heavy, and there has been an old retroflexion, a Kelly's suture is passed in addition to the posterior surface of the uterus, and this is tied with those of the round ligaments.

The **PRESIDENT** said he did not wish to speak himself, because he was prejudiced in favour of his own method.

Dr. **HODGSON** remarked with regard to the Maunsell suspension that the upper line of sutures when closed together at the sides made a *cul de sac*, which in the event of infection might be troublesome.

Dr. **HEYWOOD SMITH** said that Dr. Maunsell, in his description, spoke of a row of sutures inserted along the anterior portion of the fundus, and another along the posterior, while Dr. Macnaughton-Jones, referring to the extra ligature put in, also referred to Dr. Kelly's method of carrying stitches through the posterior aspect of the fundus too. He (Dr. Heywood Smith) wished to ask whether, in the case of pregnancy arising, ventro-suspension would not be better if it were limited to the anterior portion of the fundus and not the posterior? When the posterior portion was brought close to the abdominal wall, the fundus almost rested on the os pubis. He would like to know when the broad ligament had been tied in the way suggested by Dr. Macnaughton-Jones, if there was any dragging on the pelvic walls, and if there was a tendency for the uterus to become retroverted again?

Mr. **MANSELL MOULLIN** said Dr. Maunsell's was merely a slight modification of Kelly's operation, the only difference being that the peritoneum was attached to the fundus of the uterus more completely and in a circle round the summit, instead of to the posterior wall. In his own practice he generally performed ventral fixation. He was not prepared to say it was an ideal or a scientific method, but it seemed to him to answer the purpose, and had the further advantage that it was available in some cases where there was a slight descent also.

Mr. **BOWREMAN JESSETT** did not see much difference between Dr. Maunsell's operation and that usually performed. The only difference seemed to be that a transverse incision of the peritoneum was made and the edges were sutured to the uterus; but was this an advantage? Personally, he preferred passing one or two long sutures through the fascia and peritoneum of the parietes, transfixing the posterior surface of the uterus just below the fundus. By this method the uterus was placed in a better position than when it was sutured through the anterior wall. In two cases where he had an opportunity of *post-mortem* examination some few years after the operation, he found numerous adhesions between the peritoneum and the uterus, the latter being quite mobile. With regard to uterine suspension, his experience was not so large as in uterine fixation, and until he saw good reason for altering his opinion, he would adhere to ventral fixation in preference to ventral suspension. The operation proposed by Dr. Macnaughton-Jones was ingenious, to say the least, but he thought further experience necessary before accepting it.

Dr. **ROUTH** said Fellows should be told that one of the cases which was examined *post-mortem* had had a baby between the time of the operation and the death of the patient. He should like to know the state of the uterus of that woman in particular. It was reported that the operation had in no way interfered with labour.

Dr. **MAUNSELL**, in reply, said he did not think his paper contained anything new. Several speakers had referred to the fact that there was no difference in his operation from those of others, but he would remind them that in such matters the profession proceeded slowly, and he brought forward his modification in the hope that it might be thought a little advance on some others. He considered that the Alexander operation was the ideal, but other operations were necessary sometimes where there were adhesions, or where a tube or some disease had been removed on one side. With regard to the operation described by Dr. Macnaughton-Jones of stitching up the ligaments on both sides, he tried something of the same kind before the operation detailed that evening. In that operation he sutured the round ligament and fundus of uterus to the abdominal wall on either side, making the fixation by means of the last suture. There was no *cul de sac* left if the sinus was brought together by sutures in the way he had described.

Dr. **MACNAUGHTON-JONES** then read notes of a

CASE OF URETHRAL CYST,

which will be found under the heading of "Clinical Records" (page 109).

The **PRESIDENT** said it was interesting to hear that supra-pubic cystotomy had been performed for the recovery of the piece of catheter.

Dr. **MANSELL MOULLIN**, referring to the operation for the removal of the catheter, said he would have operated in the same way. It was easy to operate from below, but the difficulty was, it did not readily heal. In a case of the kind he had to operate four times before succeeding in closing the wound.

Dr. **ROUTH** said he had treated those cases by means of a hot iron. In the case narrated the swelling was at the lower part of the urethra. If it had been treated by a hot iron, the urethra would have contracted and the growth been destroyed. He had cured many in that way, and never thought of cutting away a portion of the urethra. It was astonishing what contraction a red-hot iron would bring about, not only in the growth but in the surrounding tissue.

Mr. **BOWREMAN JESSETT** said he could confirm the remarks which had fallen from Dr. Routh, although he preferred the galvano-cautery to the hot iron on account of the precision and ease with which it can be applied.

Dr. **Heywood Smith** said that surely the cases referred to by Dr. Mansell Moullin where there was difficulty in healing were not the same as cases of immediate operation, but applied to old-standing cases of vesico-vaginal fistula, when the edges had to be revivified. Where the opening had to be made through the vaginal wall and immediately closed he did not think any difficulty in healing would be experienced.

Mr. **Mansell Moullin** pointed out that the difficulty actually occurred in a case in which the incision was made for the extraction of a small stone.

Dr. **Macnaughton-Jones**, in reply, said he did not operate from below because of the condition of the urethra approaching the neck of the bladder. In those cases he thought the clean supra-pubic cystotomy, especially where the finger had to be introduced and care taken not to break the glass catheter, was preferable to the vaginal method. It was as harmless a procedure as the other.

Mr. **Jessett** brought forward a specimen of a tumour recently removed from a lady, æt. 65. She had a fibroid tumour for some years, which had never caused her any inconvenience. Then it suddenly began to grow, and when he saw her she had a tumour as large as a football in her abdomen, and attached to the uterus. He advised its removal, as he believed it was a soft myoma. The uterus was removed by the sub-peritoneal method. On cutting into the tissue a pint of fluid was let out, the uterine cavity was opened behind and found free from growth. The tumour was in front of the uterine wall. It was a cystic degeneration of the uterus. It was only removed a few days ago and had not been properly examined by the pathologists. The naked-eye appearance suggested it was somewhat akin to the case described by Dr. Maunsell. It was a rather uncommon condition in his experience, for a fibroid to become cystic at the age of 65.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

The sixty-fourth Annual Meeting of this Association was held in the rooms of the Medical Society of London on July 20th and 21st, under the presidency, during the early part of the proceedings, of Dr. R. **Percy Smith**, and later of the new president, Dr. T. **Outterson Wood**.

In relinquishing the chair, Dr. **Percy Smith** moved a vote of thanks to the officers of the Association who had been associated with him, expressing his opinion that the Association was extremely well served in that respect, and particularly mentioned Dr. Robert Jones, the General Secretary, and Dr. Hayes Newington (treasurer).

Dr. **Claye Shaw** proposed, and Dr. **Weatherly** seconded, a vote of thanks to Dr. Percy Smith for his conduct of the business of the Association during the past year, which was carried, and Dr. **Smith** replied.

Dr. T. **Outterson Wood** then took the chair, and read his

Presidential Address.

He first made sympathetic reference to the late Sir John Sibbald, and went on to show the progressive increase in the membership and usefulness of the Association, the members having risen in numbers from 394 in 1880 to 680 to-day. On the question of "absence on trial," which had recently been discussed, owing to the Commissioners having stated that it was illegal to bring a patient back to the institution from which he was granted leave of absence before the expiration of the time mentioned in the leave, the Association had obtained opinion that a patient could legally be brought back at any time, thus confirming the Association's reading of the Act. Dr. Wood next dealt with the dispensing of dangerous drugs, and referred to the ease with which patients could obtain them in unlimited quantities by simply taking the prescription from one chemist to another. One patient by this means obtained 1,800 grains of hydrochlorate of cocaine in a 20 per cent. solution for the purpose of committing suicide. He also touched on incipient insanity, reminding members that in a discussion in 1896 he advocated that patients whose insanity was doubtful should be placed under care and treatment, away from home, on the application of a relative supported by a written medical opinion, to a magistrate for a judicial order empowering the detention of the patient for a specified time. He referred to the large numbers of people having no knowledge of the care of the insane who were advertising for insane patients, and to the fact that the friends frequently availed themselves of that means of ridding themselves of a troublesome burden. The result generally was the removal of the patient to improper care, and the loss of the valuable early period for treatment. He advocated the registration of places and persons taking mental cases, especially in regard to so-called "nursing homes;" and in his opinion the State registration of nurses should follow the registration of the persons who employed them in these homes. A large part of the address was concerned with the question of nursing. There were now 6,900 nurses possessing the certificate of the Medico-Psychological Association, probably the largest number in the nursing world holding certificates of uniform value from one constituted authority. Last year the period of training for that certificate was fixed at three years, thus freeing the Association's nurses from the taunt of being inadequately trained as compared with hospital-trained nurses, and it would greatly strengthen their claim for inclusion in any scheme of State registration. He deprecated applying the term "attendants" to male nurses in asylums, to whom the term "nurse" was as applicable as to females. Some advocated female nurses for male insane patients; some such cases as were physically ill might be suitably nursed by women, but the proportion could not be large. It must not be forgotten that competent male nurses were as much an absolute necessity in asylum life as in private practice, and he could not help feeling that they were often what doctors themselves made them. He was not quite sure that all the stir now being made about State registration would be of much material benefit to the nurses themselves, or whether perking them up with a glistening pride might not end in their wearing a crown of sorrow, but there was no reason why Medico-Psychological nurses should be made to appear outside the pale of official recognition. The public was well protected in the matter of nurses by the members of the medical profession, who took good care to employ such nurses as were properly trained, of good character and well recommended. He doubted if any scheme could improve upon the excellent system of the Royal British Nurses' Association, under the presidency of H.R.H. the Princess Christian. The Association was largely indebted to her Royal Highness for the interest she had taken in the status of asylum-trained nurses. Finally, he declared that psychological medicine was now more intimately associated with general medicine than formerly, and he trusted there would be continued endeavour to strengthen the bonds uniting them, and which would ere long bring them into one harmonious whole.

A hearty vote of thanks was accorded to Dr. Wood for his address, and the Association then discussed the following papers:—"The Employment of Female Nurses for the Care of Insane Men," by Dr. G. M. Robertson (Larbert, N.B.); "Some Points in the Early Treatment of Mental and Nervous Cases, with special Reference to the Poor," by Dr. Helen Boyle (late medical officer of Claybury Asylum); "The Provision of Suitable Accommodation for the Various Forms of Insanity," by Dr. Wilson Rhodes (member of the Lancashire Asylums Committee); "The David Lewis Colony for Epileptics, Alderley Edge," by Dr. Alan McDougall (Resident Medical Officer); and "Notes upon the Incidence of Tuberculosis in Asylums: a

Comparative Study," by Dr. George Greene (medical officer, Claybury Asylum).

On Thursday evening the annual dinner was held at the Whitehall Rooms, Hôtel Métropole.

CENTRAL MIDWIVES BOARD.

Meeting, July 27th, 1905.

The President, Dr. Champneys, in the Chair.

After the Minutes had been confirmed, the Secretary read a letter from Dr. Wheatley, M.O.H. for Salop, with reference to a midwife who had in ignorance reported a case of puerperal fever as a slight ailment. It was agreed by the Board that the rules regarding such cases must be strictly conformed to and a medical man be called in, twice if necessary, to make a correct diagnosis.

Dr. Symons, M.O.H. Bath, wrote to ask who was to notify in the case of mother or child dying before the arrival of a medical man. He was referred to Rule E 18, which delegates such notification to the midwife.

The Secretary also read a letter from the Clerk of the Gloucester County Council enclosing a Report from the Sanitary Committee with reference to the carrying of appliances by midwives and the laying-out of the dead. It was shown that these appliances in the hands of those untrained in their use was more often a source of mischief than usefulness, and had often had serious results.

Miss Paget proposed that "The Board would suggest that illiterate country midwives should be trained in the use of appliances by the local authorities," a motion which was carried, Sir Wm. Sinclair dissenting on the grounds that it was undignified to make a suggestion which could not be enforced.

Miss Paget, with regard to the query *re* laying out the dead (expressly forbidden in the Rules), suggested a modification of the Rule in small villages where the midwife was often the only person to do it, and had very few cases to attend, but such suggestion was withdrawn when the President urged that in the first place they had no power from Parliament to dispense with the power of their Rules, and, secondly, such modification would open a very wide gap in the hedge for many midwives to evade a very important regulation.

The Secretary then read a letter from a German midwife holding high certificates from her own country, who asked for her Eng.L.O.S. oral examination to be made in German.

The President thought this might be done if, as in the Brussels M.D. examination an interpreter were paid by the candidate, but Sir Wm. Sinclair said it would be better, from an "undesirable alien" point of view, for her to wait until she knew the language better and an answer to that effect was returned.

The Report for the last examination showed 307 candidates and 225 successful candidates. The cost of examination had been £322 16s. 10d., almost covered by candidates' fees. Both Sir Wm. Sinclair and the President, as visitors, expressed their satisfaction with the class of women who had entered and the result of the oral examination; defects in the written one being often due to want of education rather than intelligence. Sir Wm. Sinclair added that the only great defect was evidence of unskilled teaching, some of the notions on obstetrics being obsolete. The President had also noticed three defects—(1) with regard to the feeding of infants on artificial food; (2) making an abdominal examination; (3) ignorance of the Rules governing their profession.

The proceedings terminated with the reading of the Report regarding cases heard *in camera* concerning misconduct and violation of Rules by certain midwives.

An invitation to hold the annual meeting of the British Medical Association next year in Toronto, presented by Dr. Cameron, was cordially accepted by the General Meeting of the Association on Wednesday.

France.

[from our own correspondent.]

Paris, July 30th, 1905.

Treatment of Paralysis Agitans.

Parkinson's disease affects always a progressive form, which it is very difficult to arrest. Therapeutic action says Professor Grassel, is purely palliative as regards the principal symptoms of the malady. Electricity in the static form appeared to have had some beneficial effect on the rigidity and the palsy.

Warm baths are not always well borne, and where they are they bring about a certain *bien être*. Suspension has been tried and in some cases has given temporary relief.

To stimulate the general nutrition the arsenical treatment has given the best results, while the serum of Trunecek in hypodermic injections has procured a notable improvement. M. Alquier prefers giving it by the mouth.

Sulphate of potash, } ½ drachm;
Sulphate of soda, }
Chloride of sodium, 6 drachms;
Phosphate of soda, 15 grs.;
Carbonate of soda, 20 grs.;
Water, 16 ozs.

A tablespoonful at the commencement of the two principal repasts, in a half a glass of water; continued twenty days per month.

Massage done with prudence improves the rigidity and the improvement continues for several months.

As to medical agents addressed to the symptoms, borate of soda has been recommended by Sacaze, given in 10 gr. doses three times a day. Notable remissions have been obtained by the salt, but it is not always well borne and provokes nausea and diarrhœa.

Hydrobromate of hyoscine in small doses (1-250th gr.) injected hypodermically, is a very efficient treatment but it sometimes produces vertigo and dizziness.

Treatment of Jaundice.

The diagnosis of the cause of jaundice cannot be always made at the outset, but a general treatment can be always instituted and constituted, says Professor Huchard, by the milk diet and laxatives.

The milk diet is very important. Every four hours a large glass of milk with two or three tablespoonsful of some alkaline water should be taken; it stimulates the biliary secretion and does not fatigue the stomach. Besides the milk, an infusion of boldo leaves might be given during the day and an occasional glass of Vittel water. The laxatives should belong to the saline series (sulphate of soda), while an enema of cold water (one quart) should be given morning and evening and retained ten minutes. The morning laxative (a teaspoonful of sulphate of soda in half a glass of Vichy water) may be suspended after eight days and replaced by benzoate of soda given in 15 gr. doses twice a day in a little Vittel water. At the end of another period of eight days, a pill of podophyllin may be given at night, while the *regime* of the patient may be a little relaxed. When the icterus lasts several weeks the attendant should advise a consultation so as not to bear alone the responsibility of a doubtful situation.

Pruritis is one of the complications of chronic icterus which commands special attention. Alkaline baths, the warm rain douche, lotions with a solution of coal-tar (a tablespoonful to a quart), icthyol (10 per cent)., &c., are some of the agents that relieve the itching. After the lotions the parts may be powdered with—

Talc powder, 4 ozs.;
Menthol, 12 grs.

If the pruritis persists, the body might be painted over twice or thrice daily with—

Icthyol, 3 drachms.;
Spirit, } 2 ounces.
Ether, }
or Glycerine, 2 ozs.;
Chloroform, 4 drachms.

Even in grave cases of icterus hope should not be abandoned.

M. Chauffard recommends the following treatment which has been successful in some cases. Two quarts of milk daily and every morning an evacuating enema followed in an hour by another enema of salt water (6 ozs. at 7-1,000). The nourishment consists in absorbing daily 3 ozs. of pig's liver, reduced to a state of pulp in a little water. The agitation is relieved by enveloping the patient morning and evening in a sheet steeped in warm water. Over the sheet is placed a blanket and the patient left in position three-quarters of an hour.

As long as the diuresis is kept up and the quantity of urea eliminated is a fair average, hope may be entertained; but where the urea falls to a drachm and a half, the prognosis is very unfavourable.

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, July 30th, 1905.

At the Free Society of Surgeons, Hr. E. Hollander introduced the subject of

The Surgery of the Pancreas.

He saw a man, æt. 32, with endemic icterus, that had come on gradually and without pain. The cachexia was increasing, both œdema and dulness were present in the upper abdomen, and there was a palpable resistance. The abdomen was opened, and as was expected a cyst of the pancreas was found; this was filled with a biliary, greenish fluid in which a good deal of cholesterin was present. A stone, embedded in the anterior wall, was removed. After the operation there were fatty stools, and a free secretion of bile from the wound. Both disappeared, and nothing remained but the pancreatic fistula, and this in its turn disappeared in about two months. The case was one of simple pancreatic cyst, through blocking with a stone. As regarded the character of the fluid, there was passage of bile into the pancreatic passages.

Hr. Korte was doubtful about such a passage, as the papilla was blocked by a stone and he rather thought that the contents of the cyst were coloured by the general jaundice. He had himself operated on a similar case a short time before, and on account of the high degree of stasis in the biliary system, he had performed cholecystenterostomy.

Hr. J. Israel spoke on the

Diagnosis of Suprarenal Tumours.

He spoke of the occasional difficulties of diagnosis in such cases, at least when no sign of Addison's disease was present. To distinguish this disease from renal tumour was difficult, for the reason that hæmaturia might be present in either, either because the suprarenal tumour had grown into the kidney, or from pressure by the tumour mass on the vena cava, thus setting up stasis in the kidney and blood in the urine. The forms under which suprarenal tumours appeared were:—

(*a*) Simple metastases in various parts of the body, no primary tumours being discoverable.

(*b*) No tumour was to be felt, although hæmaturia, paroxysmal pain, paræsthesia in the region of the lumbar plexus, pointed, when no stone could be discovered, and there was loss of power, to malignant tumour of the kidney or suprarenal body. In favour of the former were the early appearance of pain in the region supplied by the lumbar plexus, and of fever.

(*c*) The tumour was entirely supra-renal, the kidney itself remaining quite normal.

(*d*) The kidney could be distinguished from the tumour by the fingers. By further growth it naturally could no longer be distinguished. Pains and feverish symptoms came on, and death might take place from uræmia from thrombosis of the inferior cava.

If there was a large tumour, no longer separable from the kidney, then it was often very difficult, even in a pathological preparation, to distinguish whether the kidney or the suprarenal body had been the starting point.

Hr. Neuhäuser spoke on

Some Unknown Types of Renal Hyper-Nephromata.

He had examined a large number of kidney tumours out of Israel's collection, and amongst them some hyper-nephromata. These were tumours that had their origin in ruptured suprarenal germs, and were to be found in other places, but especially within the renal capsule or in the cortex of the suprarenal bodies. He had observed a distinct type in which the stroma of the tumour hypertrophied in a tumour-like manner and choked the other tumour elements.

At the Surgical Congress Hr. Weinrich spoke on

Intra-vesical Operations after Nitze's Method.

He said that from 1894 to March of the present year he had observed 399 cases of tumour of the bladder. Of these 150 cases of papilloma were operated on intra-vesically by Nitze's method—that was by the aid of Nitze's operation cystoscope. On account of the free bleeding that made a view of the field of operation impossible, the operation had to be done repeatedly in every case. The bits of tumour cut off were readily washed away with the urine. If the bleeding was very profuse the sectio alta and tamponade should be resorted to, but the bleeding had always ceased spontaneously. The advantages of the intra-vesical method were its slight degree of danger (only one death), no narcosis or long lying in bed (the patient could go about and the operation be performed in the consulting room, and he could follow his occupation). The cure was more radical than after the high operation, from which recurrences almost always took place, possibly through implantation. The actual recurrences in the 150 cases were 21, they were very amenable to renewed treatment, which was readily submitted to, In half the cases the papillomata were multiple.

German Medical Tour.

The fifth medical tour takes place this year from September 10th to the 23rd. The starting point is Munich, and the following places will be visited:—Gmunden, Ebensee, Ischl, Aussee, Salzburg, Reichenhall, Berchtesgaden, Hallein, Gastein, Innsbruck, Iglas, Brennerbad, Gossensass, Levico, Roncegno, Arva, Riva, Gardone, Salo, Sirmione, Garda, Bozen-Gries, Meran. The whole journey, including railway, carriages, and steamers, free board, lodging (with the exception of wine), and a copy of the official report, costs only £12 10s. Any English medical men wishing to take part in this tour are requested to write to Hofrat Dr. Gilbert, Baden-Baden, Germany, who will at once send programme and the necessary cards. The last date for application is August 20th.

Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, July 29th, 1905.

How can Nursing be Promoted?

At the Gesellschaft für Innere Medizin, Hamburger raised the all-important subject of the mother nursing her own child. Artificial feeding was always a dangerous proceeding, he said, and more particularly in hot weather. This looked like irony of the new apparatus of Swoboda, who had just sat down after spending half an hour on a description of the contrivance he had designed for the preparation of the infant's food at home. It is an elaborate instrument with heating and freezing arrangements. Hamburger, however, thought that mothers should make greater efforts to feed the infant with the natural apparatus rather than resort to artificial means on the flimsiest excuse given by a midwife. The profession, he assured us, was not free from blame in this respect, which certainly did not add to our credit. He contended that the midwife or medical adviser who encouraged such artificial feeding was responsible for the life of the child, and if the law were more careful in the investigation of this responsibility we would have a lower infantile mortality. It should be made penal for a midwife to advise, and a report demanded of the medical attendant for such a serious step.

Hock admitted the truth of the rapid increase of hand-fed babies, and thought that midwives should be so impressed with their duties in this matter as to inform the mother that this was a serious drawback, and should always be eschewed.

Sternberg warned the meeting of another factor that should not be lost sight of in their condemnation, *viz.* insurance. A very good clause had been added to the operative department that no benefit could be claimed till six weeks after the confinement. This was a step in the right direction, but it did not go far enough. Yet Pfaundler said the midwife was our greatest barrier for child protection. They were a kind of uneducated family adviser that did infinitely more harm than good. The only thing left for the medical profession was to institute a proper feeding propaganda. Bunge's publication was full of instruction, and his articles on alcoholism and nursing could not be disputed—the health of the mother is the best test of the milk.

Knapp thought that no less than 95 per cent. of the females confined could suckle their own child if they wished, but society was against this duty. The Berlin Town Council spent 90,000 marks on the laudable object of getting mothers to nurse their own babies. Could Vienna not follow this example with advantage?

Reither advocated better instruction for our midwives. They should pass a rigid examination in the feeding and general nursing of infants. The newly-born were the victims of ignorance in this so-called age of enlightenment.

INSUFFICIENTIA VALVULÆ TRICUSPIDALIS.

Reiter showed a case, æt. 45, with insufficiency of the tricuspid valve, not a relative condition, but a real organic lesion. The murmur was musical, located to the site of the tricuspid and occurring at every systole of the heart. Since February, 1903, the patient has been under observation with all the signs and symptoms of non-compensating disturbance. He asked the members to tell him what was the cause of the morbid change in this particular ostia. It must have been due to some myocarditis, to which no place in the clinical history can be assigned. The most common cause in these cases is articular rheumatism, which is quite absent. Even rheumatism would leave the case unique as the left side of the heart is usually attacked, and not the right. Bamberger gave it as his experience that only two cases of the tricuspid occurred in 250 cases; Huchard met with it more frequently—two in fifty. The patient had never suffered from any of the infantile diseases, such as diphtheria, scarlet fever, &c., when he was young, although he tells us he had measles when he was eighteen years of age, which does not usually leave any cardiac lesion. In 1898 when the patient was thirty-nine years of age, we hear of him having inflammation of the lungs. Even this gives us no clue to myocarditis, and the present vitium. Gonorrhœa and epididymitis left no bad effects. The symptoms of the patient when first received into hospital were palpitation, difficulty of breathing, and swelling of both legs, which first commenced in 1902. The objective changes in the heart must have originated somewhere about 1898 and 1902, or between thirty-nine and forty-three years of age.

Whether the pneumonia left an ulcerated endocarditis we have no reliable testimony or symptoms to fall back upon, although it might be a suggestive etiology. The patient acquired syphilis in 1903, when he was thirty-four years of age, and was treated with thirty-four inunctions. Here we have a clinical picture of the cardiac lesion occurring five or nine years after the supposed infection, and attacking the right side of the heart alone, approaching with arhythmia, such as bradycardia, reducing the heart to thirty beats for weeks at a time associated with difficulty of breathing, and finally pains in the long bones and the presence of cutaneous gumma. The common cardiac remedies for toning the heart, such as digitalis, strophanthus, caffein, &c., were administered with out relief, while energetic antisyphilitic medicines gave distinct subjective relief, and greatly modified the arhythmia.

Operating Theatres.

KING'S COLLEGE HOSPITAL.

ABSCESS OF THE LUNG.—Mr. PEYTON BEALE operated on a man æt. about 43, who had been under the care of Dr. Dalton, and was suffering from an abscess in the lower part of the left lung. His history was not easy to obtain as he was an Austrian, but it appeared that some time ago he had gastric symptoms which rather pointed to the presence of a gastric ulcer. Recently, however, he had suffered from an affection of the lung, and had for a week or two been expectorating small quantities of very fœtid pus. As this continued, and as the patient was steadily losing ground, Dr. Dalton considered it desirable that the abscess in the lung should be drained. On the left chest below the angle of the scapula, there was a small area of absolute dulness and a certain amount of impairment of resonance extending around it for some distance. The following operation was performed:—The rib in the centre of the area of dulness was exposed, the periosteum loosened from it for a distance of two inches and that portion of rib was removed. An incision was then made and a fairly large quantity of very fœtid pus at once escaped from a cavity in the lung which might be estimated at about the size of a tangerine orange, but which was very irregular in shape. On exploring the cavity with the finger its limits in every direction were easily defined, and no sinus or passage could be detected extending upwards, downwards, or inwards. At the centre of the incision the layers of visceral and parietal pleura were obviously in contact, but only for about one inch; above and below this the incision had opened the pleural cavity, from which there escaped a quantity of clear fluid estimated at about ten ounces. On examining the pleural cavity with the finger, it was found to be obliterated in the form of a band reaching inwards to the vertebral column. The abscess cavity in the lung was as far as practicable shut off by sutures from the pleural cavity and packed with gauze plugs. Mr Beale said that this was evidently an abscess of the lung, the infective source of which must have been towards the vertebral column; such infection had probably spread up close to one of the crura of the diaphragm, and so reached the root of the lung, and travelled outwards. The source of infection might have been a gastric ulcer situated on the lesser curve of the stomach, and around which adhesions had formed before it had ruptured. Another possibility was an acute pancreatitis which by the formation of adhesions had been prevented from infecting the peritoneal cavity. Another possibility, he pointed out, was a spinal cavity, though in the case he had just operated on there were no symptoms suggesting this. A subdiaphragmatic abscess, he remarked, might be formed in connection with an abscess of the liver, or following an acute suppurative appendicitis; in the latter case it was very common indeed, he said, to find the pus travelling upwards, following the ascending colon, and sometimes reaching as far as the splenic flexure. In the case just operated on the difficulty of obtaining any reliable history from the patient made it, he thought, impossible to say which of all these conditions had caused the lung abscess, but the probability was that an old gastric ulcer was the initial source of the trouble. The patient's condition at time of operation, he said, was distinctly critical, and such as to preclude any real attempt at ascertaining the source of infection.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 2, 1905.

THE PRACTICAL ISSUES OF MEDICINE.

Among many interesting addresses delivered at the Leicester meeting of the British Medical Association, that of Dr. Maudsley was not the least attractive. As a matter of fact his discourse was of the philosophical nature that illumines the path ahead hardly less than that which we are actually traversing or have already left behind. The field opened up by scientific investigation has become so extensive and at the same time so specialised that medical men, both collectively and individually, are somewhat apt to lose sight of the practical issues which furnish incentives to the generalisations that form the basis of our labours as a learned profession. It is well, therefore, now and then to pause and take a calm survey of the situation not only in regard to the present, but also to the post and the future. The doctrine that prevention is better than cure is as old as the hills, but it nevertheless forms as strong and unerring a guide to the pathologist of the twentieth century as it did to the mediæval philosopher; or, for that matter, to reasoning mankind in any of his early or prehistoric stages. Yet that lesson, elementary and self-evident as it may seem, has yet to be learnt by the world at large, so far as the administrative side of public health is concerned. In many local authorities, urban as well as rural, the question of cost is allowed to stop the wheels of progress with the result that the community have to pay an enormous indirect taxation in sickness and death, due to preventable disease. The standing reproach of an excessive infantile death-rate is ever with us, The evil might be to a great extent removed by the installation of municipal supplies of pure milk in our great towns. Before the end of the present century it is probable that the physique of the nation will be carefully fostered in that way as an item of ordinary natural expenditure. The money thrown away in the recent war in South Africa, for instance, would have become an invaluable national asset had it been expended in the installation of municipal milk supplies for the poor of large towns of the United Kingdom. Dr. Maudsley dwelt pointedly upon the enormous saving of human life that had resulted from the increased attention paid to zymotic diseases within the last few generations. At the same time he wisely insisted that in the sphere of beneficent activity the physician had more worlds to conquer before he would be entitled to rest and be thankful. The splendid triumphs already attained are to be regarded merely as pledges of victories that still lie hidden in the womb of futurity. After all said and done, however, we find ourselves falling back upon the gospel of prosaic simplicity preached by the pioneers of public health. Pure air, pure water, pure food, with wholesome environment and sensible living, represent the beacon-lights of the sanitarian. In discussing the prevention of consumption, Dr. Maudsley touched upon various points of essential importance to the public. His approval of sanatoria for the treatment of sufferers from that disease is carefully qualified. But while he insists that isolation and special treatment offer no royal road to the stamping out of human tuberculosis, he nevertheless brings into prominence another crucial feature of the situation. Are we not too prone, he asks, to disregard the predisposing influences of heredity? There can be little question that in our joy at finding out the curability of a certain percentage of cases of lung consumption, we have more or less forgotten the medical experience garnered by our forefathers of a pre-bacterial age. It is well, therefore, to be reminded, with curt directness of phrase, that so long as consumptives become fathers and mothers it seems hopeless to expect to cut off the entail of this terrible scourge. This observation opens up moral issues of the widest and gravest character. How can any responsible human being consider himself entitled to bring into the world children who will be exposed to the curse of Cain in the form of some disabling malady, such as syphilis, tuberculosis, or insanity? Shall we adopt Dr. Rentoul's suggestion and sterilise the insane, the tuberculous, and other degenerates? Whatever decision may be arrived at ultimately by society as to this moot point, one may surmise that the general tendency will be to place increased restrictions upon undesirable marriages of the kind indicated. So far as lunatics are concerned, we have them under more or less control, and it would be comparatively easy to prevent their reproduction. As things stand, the way in which insane persons are periodically released from asylums and permitted to procreate fresh potential lunatics is simply a scandal. Although on the whole the tone of the address under notice was somewhat pessimistic, it nevertheless held beneath the surface a firm and reassuring hold upon the principles that must infallibly maintain the onward and upward progress of mankind as the dominant factor in the world's evolution.

PERNICIOUS ANÆMIA.

THERE are few subjects in medicine which have aroused more discussion regarding etiology and pathology than pernicious anæmia, and there is certainly no well-recognised clinical entity whose pathology is still so much a matter of speculation. In the classical description of the disease given by Addison exactly fifty years ago, he remarks: "On examining the bodies of such patients after death, I have failed to discover any organic lesion that could properly or reasonably be assigned as an adequate cause of such serious consequences." It can hardly be claimed that on this point we have got much beyond Addison, although it is true that a fairly definite pathological anatomy has now come to be connected with pernicious anæmia. The most noticeable feature of this anatomy is the change in the bone marrow, first noted by Cohnheim in 1876, and it is consequently in the bone marrow that many observers from his time down to the present have sought the essential lesion of the disease. The change in the marrow, which has been described as a reversion to embryonic type, consists in a diminution in number of the erythrocytes and normoblasts, and a comparative increase of cells of megaloblastic type. It is not necessary to assume, however, that this condition is the primary lesion, as will presently be seen. Other observers see in pernicious anæmia a resemblance to certain toxic states, though as to the origin of the assumed toxin there is the greatest difference of opinion. Hunter holds very strongly that the toxin is the result of a septic condition of some part of the alimentary canal—mouth, stomach, or intestine—and he has discovered deep-seated inflammatory changes of the alimentary system in many cases of the disease. His theory is, in fact, that pernicious anæmia is a chronic infection of the alimentary canal, the changes in the blood and marrow being only symptoms of severe disturbance thence arising. Whether one agrees with Hunter or not in his view of the origin of the toxin, there are strong arguments in favour of the view that the changes of the blood in pernicious anæmia are due to the circulation of a toxin, however derived, which has a special action on the red blood corpuscles. It is fair to assume that given such a toxin as would have special action on the red blood corpuscles, whether in the circulation or in the marrow, it would have similar action on cells in the immediately precedent stage, namely, the normoblasts, and would consequently produce the typical condition found in the marrow. In certain experiments (*a*) recently conducted by Bunting, a condition of the blood and bone marrow closely resembling that of pernicious anæmia was produced by injection of animals with ricin. While nothing can yet be said to be proved regarding the pathology, as distinct from the morbid anatomy, of pernicious anæmia, yet it is not too much to say that the toxin theory is at once the most promising and the most comprehensive.

A JUDGE ON CRIMINAL INSANITY.

THERE is no part of our English jurisprudence less satisfactory than the legal view of mental responsibility and irresponsibility. The whole matter demands impartial investigation and the formulation of fixed scientific principles for the guidance of our judicial system. Under existing circumstances the plea of mental irresponsibility, if raised on a prisoner's behalf, is disposed of on grounds that often appear to be irrational, groundless and unscientific. In the case of the Birmingham lawyer, Edalji, who was sent to penal servitude a year or two ago for the mutilation of cattle, we pointed out that if he were really guilty of such a purposeless act he must have been insane, and that to send him to prison instead of to a lunatic asylum was simply to perpetuate a violation of British justice. A petition to that effect was presented to the Home Secretary, the Right Hon. Aretas Akers-Douglas, but it elicited no satisfactory answer. Inasmuch as the petition in question was signed by a great many medical men, including some of the most distinguished authorities on mental alienation in the Kingdom, we consider that a courteous and fully reasoned reply should have been forthcoming from the Home Office, no less on the score of courtesy than on the desirability of defending the British law against any breath of suspicion of unsoundness. The Home Secretary, however, Mr. Aretas Akers-Douglas, is in no sense a politician of strong and impartial character. In various recent cases where the police system has been grossly at fault in the imprisonment of innocent persons, his chief desire appeared to be to excuse his subordinates. Doubtless the Home Secretary has obtained expert advice upon the point of the insanity or otherwise of the unfortunate lawyer convicted in the Great Wyrley cattle-maiming case. The public, however, no less than the medical profession, is entitled to know upon what scientific grounds the decision has been made to regard the prisoner as a sane man. Possibly, as the prisoner in that case was convicted upon purely circumstantial evidence, and as another man in the neighbourhood has since been convicted of a similar offence, Mr. Akers-Douglas has good reasons of his own for not re-opening the case. Anyway, we regard the imprisonment of that man without full and public statement by a skilled impartial commission as to his state of mind as a grave judicial scandal. Last week another exhibition of legal prejudice was given in the Central Criminal Court. The judge, Mr. Justice Ridley, had

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(*a*) "Johns Hopkins Hospital Bulletin," June, 1905.

apparently made up his mind beforehand as to the absolute sanity of the prisoner Devereux, who was accused of the wilful murder of his wife and children. It appears that the defence secured by some means an examination of the prisoner by a medical man, Dr. Forbes Winslow. An account of his visits subsequently appeared in the newspapers, and the witness in question admitted that he had communicated the results to persons who had "spoken" to him. Conduct of that kind, assuming it to be as stated, is no less unworthy of the honourable traditions of the medical profession than obviously contemptuous of the jurisdiction of the Court. For all that, we see no reason why the judge should discourage witnesses coming forward with evidence as to the mental condition of the accused. A clergyman, for instance, testified to having known the Devereux family for years. He considered the prisoner to be deficient in intellect, and on one occasion the accused had posed as an American millionaire. Mr. Justice Ridley, however, turned into ridicule this evidence, which will appear to most medical men to be pertinent enough. The plea of unsoundness of mind was not advanced in this case, and therefore the Court was entitled, by this strict letter of procedure, to exclude evidence bearing on that point. At the same time it was shown that the grandfather, father and aunt of the prisoner attempted suicide, but the judge roused the laughter of his Court by asking whether anything was known of his great-great-grandfather. In addition to the foregoing relatives an uncle had been certified insane. We venture to suggest that these facts, coupled with the unusual circumstances of the crime for which the prisoner was on trial, suggested an adequate skilled examination of his mental condition. Instead of that the learned judge refused to call Dr. Scott, the medical officer of the gaol, to give evidence as to the prisoner's state of mind. We venture to submit that the whole incident presents in the strongest possible way the absolutely dogmatic, uninformed, and dangerous legal attitudes in dealing with questions involving soundness of mind. There will be no real security for the public in this important detail of administrative justice until the services of an impartial body of expert investigators are at the disposal of our judicial system. First let us have a Royal Commission of Inquiry as to the working of the present method of expert advocacy paid for by opposing parties in legal investigations and prosecutions.

Notes on Current Topics.

Central Midwives Board.

The last meeting of the Central Midwives Board we are glad to learn, showed some slight improvement in the administration of business. The mass of comparatively trifling business with which the time of the meeting has hitherto been consumed was considerably reduced after a protest from the medical members. An opportunity was thereby afforded for the discussion of matters of more vital importance. There is still plenty of room for improvement in the organisation of the Board. We suggest to Dr. Champneys, if he be unacquainted with the ordinary conduct of the business of a great central body of this kind over which he presides, that he should call in skilled advice upon the point. The protests of Sir William Sinclair and of Dr. Ward Cousins have been constant and emphatic, but appear to have been for the most part systematically ignored. It is simply farcical to suppose that men of their standing and experience should be brought up to London to discuss trifling details that might be perfectly well relegated to a sub-committee with powers to act or to report as might be deemed advisable. There is another side of the question. The two gentlemen named enjoy the respect and confidence of the medical profession, an approval which Dr. Champneys appears to regard with indifference. We shall be interested to learn his attitude with regard to the proposal of a lay member at the last meeting that midwives should be instructed in the use of "appliances"—meaning thereby, it is to be presumed, such articles as catheters, midwifery forceps, vaginal specula, uterine catheters, and so on!

Vital Statistics of London.

The Registrar-General's returns for 1904, commented on by Dr. George Newman in the July number of the *Practitioner*, give very interesting information as to the incidence of certain diseases on the inhabitants of London. London has for years been famous as a healthy city, and it is satisfactory to find that the death-rate in 1904—16·6 per 1,000—was, with the single exception of the previous year, the lowest on record. One obtains some idea of the meaning of this figure when it is remembered that the death-rates of New York, Moscow, and Dublin, are 22·6, 27·6, and 25·2 per 1,000 respectively, while the death-rate for the whole of Ireland, with a population just less than that of London, is 17·5 per 1,000. In London, as might be expected, the highest rates are found in the central districts, and very low rates indeed round the circumference. Comparing the mortality of particular diseases to-day with that of twenty years ago in London, it is gratifying to find that in the case of all the acute infectious diseases there is marked improvement. This is noticeably so in the case of small-pox, scarlatina, diphtheria, and typhoid fever, and to less extent in the case of measles and whooping-cough. In the case of epidemic diarrhœa and of tuberculosis there is no improvement. The last-mentioned disease, followed closely by malignant disease, nervous diseases, and diseases of the heart and pneumonia, none of which show any marked improvement, contributes most largely to the death-rate. It is not a matter of self-congratulation, however, that the marriage-rate and birth-rate tend to move parallel with the death-rate, and last year both of them reached their lowest point since 1855. That the birth-rate is not entirely influenced by economic causes is shown by the fact that the decline is greatest in the most wealthy districts, such as Hampstead and Kensington, and least in such places as Poplar and Stepney.

Dangers of Cold Storage.

Nowadays, when cold storage of food has become almost a necessity of civilised life in large cities, it is well that medical men should be conversant with the dangers arising therefrom. It is commonly recognised, of course, that meats which have been frozen are likely on removal from ice to undergo more rapid decomposition than would fresh meat. The changes of temperature involved in freezing and thawing apparently cause such changes in flesh as to render it more readily a prey to the bacteria of putrefaction. In the case of some meats, however, the change takes place much more rapidly than in the case of others, and everyone is aware that fish, game, and poultry, removed from cold storage, "go bad" more quickly than carcases of beef or mutton. Apart from other points of difference, such as the quality of the meat itself, this is due in the main to the fact that the carcases of beef and mutton are eviscerated before being placed in the cold chamber, while the bodies of fish and game are often placed therein whole. The result is that within a few minutes after removal, the entire body may be soaked with toxins, and ingestion of food in such a condition may cause very serious poisoning. It is unfortunate that it is so frequently the custom of the trade to stock fish and game whole, as if eviscerated immediately after being killed they would keep for a much longer period.

Tobacco and Health.

In spite of the impressive series of conditions of disease treated of by the writers in the symposium on "The Effects of Tobacco in Health and Disease," in the July number of the *Practitioner*, we do not think many lovers of tobacco will be disturbed in their habits by the views there set forth. There is, indeed, on the part of most of the writers, a latent sympathy with the "vice" which seems to proclaim them as lovers of the weed themselves. It is true that they point out the evils of smoking by certain subjects in certain conditions, but the condemnation is somewhat formal and impersonal. Thus, as all the writers are, we believe, full grown adults, we are not surprised to learn that "there is a general consensus of opinion that it [smoking] is very distinctly harmful to growing lads." In adults, however' "it will stimulate the brain to increased activity, and it will also produce a soothing effect in conditions of excitement." It would almost be possible from a study of the opinions of the different contributors to discover to what form of the weed each is addicted. There is no doubt that Sir Lauder Brunton smokes cigars for he condemns both pipe and cigarette. In this opinion he is at one with Mr. Lambert Lack, who has a particular dislike—professional, of course—for Egyptian cigarettes, but we fear there is a conpiracy against the use of cigarettes, since no one has a good word for them. Indeed, the only satisfaction the cigarette-smoker can take to himself is indirect, when he learns that to a clay pipe is due a series of morbid conditions of the mouth culminating in epithelioma. It is perhaps just as well that the writers, being possessed of a just sense of proportion, have not in these pronouncements taken themselves too seriously, for assuredly no lover of tobacco will be terrorised from his source of pleasure by academic statements of the dangers to which he is exposing himself.

Common Salt as a Poison.

We are certainly not accustomed to regard common salt as a poison, but rather as one of the most innocuous of chemical bodies. Itself a necessary of human life, its solution is commonly employed as the physiological substitute for the natural juice of the body. That, however, in large quantities it may prove a drug of serious power is shown by a case recently reported by Dr. Charles Combs. (*a*) By some misunderstanding, to a woman, aged thirty-five, after an operation for removal of an ovary, 500 cubic centimetres of a concentrated saline solution were injected instead of normal solution. In all, she received subcutaneously about a quarter of a pound of sodium chloride. The patient shortly became comatose, and after six hours of coma, passed into a state of mania. The pulse became too frequent for counting, and the respirations went up to seventy in the minute. There was insatiable thirst and constant vomiting and death occurred in twenty-four hours. Examination of the blood showed that the red corpuscles were much shrunken and crenated from osmosis and there is little doubt that death was due to oxygen-starvation due to complete loss of function of the red blood corpuscles.

Facilis Descensus.

Mr. Eustace Miles has long been known as a faddist on such subjects as diet and training, and as faddists have to be suffered gladly in a modern community he has hitherto been met with the chaff that seemed suitable to the occasion. The principle of answering a fool according to his folly does not seem to have had the effect of showing people the threadbare absurdity of classical coaches from Cambridge abandoning the literature of the ancients for the practical application of modern theories of physiology and pathology. We notice in the columns of the daily press certain flaring advertisements in which sufferers from various ills are invited to consult Mr. Miles by correspondence, so we conclude that the cobbler has decided definitely to abandon his last, and to join the ranks of let us say, the unqualified practitioners. Whether Mr. Miles has placed himself in the hands

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(*a*) *American Med*, April 22nd, 1905.

of the "advertising staff" of the *Times* or in those of some other enterprising agents, he has certainly succeeded in producing announcements which for hyperbolic statement and bad taste it would be hard to beat. To every reader he "sends the message of health." If the health of any member of the family is not satisfactory, let Mr. Miles have particulars. Mr. Miles' experience and individual attention are at the sender's disposal. Mr. Miles is every day treating successfully obstinate cases which (in leaded type) have defied other treatments for years, and makes all the other magniloquent pretensions we are accustomed to in the most unabashed quack announcements. As part of his stock-in-trade Mr. Miles displays to the public the academical distinction of M.A.Camb., after his name—a fact which it may be hoped will at least lead to remonstrance from the authorities of the venerable college from which he graduated. If after dallying with the "unclean thing" for *nemo repente fuit turpissimus*, Mr. Miles has decided to go the whole hog, he need not involve in his career the University where at least he might have learned better things. It is not unlikely that the University and other important bodies may have something further to say upon the matter.

The Meat of the Poor.

The British working man is, in spite of all temptations, a meat eater, and while he is prepared to pay for his beef and mutton, it is as well that he should be supplied with honest joints. Some food reformers may wish to see him subsist on cabbages and patent foods, but so far he has thriven well on meat, and there is no reason why he should not continue to do so. In Germany and France horse-flesh, because of its cheapness, is eagerly bought by the poor, and there is no particular reason why such meat should not provide sufficient nourishment for its consumers, even though it lacks the delicacy and tenderness of cow and sheep flesh. In Berlin and its suburbs there are no less than two hundred and fifty horse slaughter-houses, and even in good restaurants it is asserted that dainty "kickshaws" not infrequently are manufactured out of horse-flesh. Certainly there can be no doubt of the orgin of the meat in many German sausages, for in Hamburg, one of the centres of the trade, 5,000 horses are killed for food each year. In the East End of London, however, Dr. Thomas, the medical officer of health for Stepney, has unearthed a scandal which may well engage the attention of sanitary committees. It appears that the cats-meat vendors, who deal in the most undesirable parts of animals, are not confined to catering for the tastes of their feline customers, but may, and often do, prepare and sell meat for human consumption side by side with that pertaining to their legitimate occupation. Diseased meat is often sold for cats, and if these dealers are caught with such meat on their premises, they always excuse themselves by saying that it is not intended for man. On the other hand, Dr. Thomas points out the temptation that undoubtedly exists to work up such meat into brawn and other such preparations, and he concludes that it is desirable that the two trades should be definitely severed from each other.

Nurses and Their Critics.

"An Outsider," who contributed an article on nursing to one of the nursing papers some week back, (*a*) can hardly have been surprised when she (we suppose it is "she") found a hornet's nest about her ears. The article was, indeed, a scathing criticism on the narrowness of outlook and character of the average nurse, a narrowness for which the conditions of hospital and nursing life are held responsible. There is no doubt, of course, that the life of a nurse is extremely exacting, and requires perhaps more than any other occupation for women, the sinking of one's own tastes and wishes. A nurse, more than most working women, lives in the midst of her work, and has, except in her brief annual leave, but little chance of getting away from it. It must not, however, be too hastily argued from this that an unusual narrowness of character must result. While it is true that complete concentration on any one occupation has a narrowing effect, it must not be forgotten that this effect is likely to be less in the case of nursing than in the case of most other occupations. A nurse's work is in truth a liberal education. She is brought into contact with more varied phases of human life and conduct than perhaps any one else, not even excepting the physician and the priest, and she must be dull indeed if her experience has not a broadening effect on her own outlook. It is no wonder that many nurses have indignantly repelled the rather superior criticisms of "An Outsider."

Lest We Forget.

The lawyer is said to envy the doctor in that whereas his own mistakes are dissected with minute care in open court, the doctor's bad work is soon hidden by mother earth. This joke we are thankful to think, is more of a verbal pleasantry than a solemn accusation, and the lawyer's mistakes at any rate do not have such momentous consequences—attached to them as do the doctor's. Moreover, if a doctor be ever caught tripping, there are generally plenty of friends to keep the act fresh in the memory, even if the coroner's court did not exist for the purpose. Fortunately in England the medical man is spared the opprobrious rite of being expected to hang a lamp at his front door for every patient who dies under his care, as is the unhappy lot of the practitioners in "far Cathay." Even if the number of deaths has not to be recorded for public comment, the doctor has to suffer in other, and in some ways, less desirable, manners from reflections which he is unable to meet in open conflict. In Pennsylvania, where we suspect the law of libel must be very lax, a resident has

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(*a*) *Nursing Times*, July 1st, 1905.

recently taken a course of action to which over here we fancy there is no parallel. He has erected a monument in imperishable granite over the grave of his wife, on one side of which is carved the usual description of the deceased and a tribute to her virtues, and on the other, the following inscription—

> " A victim of Chloroform Poisoning and Shock,
> The result of a Doctor's Negligence."

It would certainly add to the terrors of practice if the relatives of each patient who died were in the habit of carving on the tombstone their candid opinion of the doctor's treatment in the final illness, and it is to be hoped that the custom, if it become at all general, will be confined to the other side of the Atlantic.

Mr. Coroner Troutbeck and the British Medical Association.

MR. CORONER TROUTBECK, who has so successfully roused the dormant energies of the medical profession, seems to have friends in high quarters. At any rate, that inference appears to be supported by the fact that the representatives of the British Medical Association have been simply ignored by the Prime Minister. Accordingly, it is not altogether a matter of surprise that the representatives at the Leicester meeting last week passed a vote protesting indignantly against Mr. Balfour's omission to reply to the communications of the Assiociation. The letter dealt with the refusal of the Lord Chancellor to pronounce judgment on the charges against the Coroner for South West London. At such a time, when the Government is receiving many kicks and few halfpence it seems a pity that the Prime Minister should fail to conciliate so powerful a body as the medical profession. Possibly his estimate of the weight of medical men as a political influence is based on former experiences of their want of unity and backbone. It remains to be seen whether Mr. Troutbeck's arrogance and insolence have roused a sterner spirit in the profession. It is intolerable that the Lord Chancellor should be permitted to play into the hands of a wilful Coroner by failure to discharge the duties appertaining to the woolsack, for which the nation, including the medical men, pay an extravagant salary.

Blackmailing Charge Against a Sanitary Inspector.

THE future of public health administration must obviously depend to a great extent upon its popularity, and the latter upon its purity. It is therefore of the utmost importance to exercise a constant vigilance upon the proceedings of local sanitary authorities. In London an exposure of wholesale official corruption recently took place in Holborn, and it is to be regretted that one of the most influential offenders was allowed to go scot free by a vote of the Borough Council. In another district, Marylebone, a grave charge has been made against a sanitary inspector. A builder in the neighbourhood alleges that between the years 1898 and 1900 the inspector received from him blackmail to the extent of £240 upon eleven orders amounting to £905. The Sanitary Inspector has been suspended pending further action by the Local Government Board. It is obvious that abundant opportunity for rascality is afforded to sanitary officials by virtue of their position. If common rumour is to be believed a great deal of this kind of abuse exists in various parts of the United Kingdom. Clearly the dishonest inspector has merely to condemn drains and other parts of a house and blackmail either the owner or more conveniently the builder whom he recommends to the householder. Offences of this kind deserve rigorous punishment, for they strike a coward's blow at the health of the nation.

Resuscitation from Chloroform Poisoning.

CHLOROFORM with its disadvantages still continues an indispensable adjunct to the anæsthetist's resources, and were it possible entirely to eliminate the risk of syncope and respiratory failure during its administration there can be no doubt that it would supersede ether from the position that the latter now holds in the practice of many. But it may be taken as certain that while sudden deaths continue to occur in the hands of the most experienced anæsthetists, there is a proportion of cases in which no blame of any kind can be attributed to the administrator. The methods of resuscitation from chloroform poisoning are at best untrustworthy, and it may, therefore, be of interest to note a series of experiments by Dr. Joseph Winter on the applicability of suprarenal extract under such circumstances. Suprarenin, as is known, powerfully raises the blood pressure, and as the first symptom in chloroform poisoning is a fall in blood-pressure, it would seem eminently reasonable to try the effects of suprarenin under such circumstances. Dr. Winter began his experiments by isolating a mammalian heart and running 1-1,000 chloroform solution through the coronary arteries till the heart ceased to beat. It was then found that by replacing the chloroform solution by one of suprarenin of the same strength, active contractions were again set up. Cats chloroformed until heart and respiration had ceased were brought round by injecting suprarenin solution into the left ventricle, after other methods had failed to revive them. Intravenous injection was found to be without effect. Dr. Winter suggests that in cases where the ordinary methods of restoration from chloroform narcosis have failed, solutions of suprarenin should be injected into the left heart, and artificial respiration begun. The plan seems well worthy of trial.

Backache Remedies.

ONE of the most common symptoms complained of by suffering humanity is backache " Sacralgia " it is often termed, when the real cause of the symptomatic condition is perhaps not quite acurately determined, and this word carries with it a vague sense of scientific propriety, comfortable alike to the physician and the patient. Women are greater sufferers than men in this respect, probably because in them constipation is more frequent, and the presence of a loaded sigmoid flexure is commonly productive of backache in nine cases out of ten. Muscular rheumatism so-called, is another mask worn by the same complaint, though this condition may be caused by physical over-exertion or prolonged muscular strain. Certain phases of the gouty state are also characterised by severe paroxysmal pain in the lumbar and sacral regions. This is the variety which yields so promptly to alkaline treatment. Then there is the backache of renal troubles, with or without associated lithiasis. A considerable fraction of cases is left over in which there is no discoverable cause. The pain is definitely lumbar or sacral, and it really does incapacitate the sufferer from following his or her occupation. These are the cases that are lured by the seductive offers held out by much-advertised quack remedies, offers that promise instant relief and permanent freedom from pain. It is all so simple—merely the consumption of a "specially prepared" pill, alleged to be drawn from "purely natural sources," with, of course, the sanction of science thrown in, after which future bliss is certain! The removal of long-retained fæces will do much to take away the dragging pain which is such a feature of this condition, but the necessity for a more or less continuous use is one of the drawbacks of the vegetable purgatives. A timely visit to a gynæcologist will clear up many an obscure backache as will also a rectal examination, neither of which procedures should be neglected in those cases which do not speedily yield to the ordinary methods of treatment.

Bathing Fatalities.

Now that the bathing season is in full swing, every day brings with it a crop of fatalities from drowning, and though a good deal has been done at the frequented watering-places to prevent such accidents, it is doubtful if the full necessities of an efficient organisation are grasped. From some elaborate observations of Margulies, recorded in the *Berlin Klinische Wochenschrift* for June 19th, we learn that the act of drowning comprises five successive stages. First, that of surprise, which lasts 5 to 16 seconds and is characterised by gasping respiration. Following this is the second stage, during which respiration is in abeyance for about a minute. This is followed in turn by the third when deep respirations are taken—and water is swallowed. After continuing for from 60 to 150 seconds the fourth stage is reached, in which consciousness is lost and respiration ceases. This fourth stage lasts about one minute—and is followed by the final one during which for 30 to 50 seconds irregular gasping respirations are made. Taking, then, the longest time for each stage, we find that the whole process of drowning is completed in five and a half minutes, and under some circumstances it may be much less. Margulies considers that the prospects of recovery are good if the subject be rescued during the first minute, fair during the second, and less and less favourable in the succeeding stages. Now as accidents to bathers almost always take place suddenly, it is obvious that a rescue service, if it is to be of any value, must be always on the alert and ready to proceed at a rapid pace to the scene of an accident; moreover, that its *personnel* should be comprised of several good swimmers and divers, who have been well trained in the methods of rescue. The usual old man in a boat who paddles about some distance from the shore is the merest salve to the consciences of those responsible for the safety of bathers, and the sooner he is superseded the better.

The Joy of Living.

THE mere sense of existence is a pleasurable thing to a healthy individual. The young man rejoices in his strength, for has he not that buoyancy of spirit and suppleness of limb which are the natural accompaniments of "good form" of brain and muscles? This physical sensation of *bien-etre* is always enhanced by conditions of high atmospheric pressure and by increased brightness in the world around us. In other words, it is a question of the degree of æration or oxygenation of the blood. The benefits derived from a so-called change of air are chiefly attributable to a diminution of those impurities, gaseous and suspended, found in the atmosphere of towns, and to the presence of a small amount of oxygen in the nascent state. Tales in which the scenes are laid upon parts of the earth's surface where the air is not up to the normal standard, or upon lunar territory, are still popular among a certain class of readers. Various speculations have been made, from time to time, as to the effects which would be produced upon the human race by wholesale modfications in the composition of the atmosphere. The latest fancy of this sort emanates from a new Parisian magazine in whose beautifully-illustrated pages are depicted scenes descriptive of what might conceivably be supposed to happen were the air to contain a too generous proportion of oxygen. The reviving effects of this gas are well known, and they are fully utilised in practical medicine, but it cannot be said that death has even occurred, or even wild delirium, merely as a result of inhaling it in a more or less concentrated form. The processes of metabolism, including internal combustion, certainly go on with increased vigour when the blood is surcharged with oxgyen, but it is very doubtful if the human race would become extinct by "consuming up all its organic tissue," even were such an unlikely event as the absorption of all atmospheric nitrogen probable.

PERSONAL.

ON July 26th, His Majesty the King formally opened the new Royal Naval Hospital at Chatham. The buildings will contain 600 beds with accommodation for 90 members of the staff.

MR. PHILIP VAUGHAN has promised to subscribe £5,000 to the £50,000 the committee are raising for the Bristol Royal Infirmary.

THE name of Dr. Charles A. Hayman, of Clifton, has been added to the Commission of the Peace for Bristol.

IN accordance with the provisions of her late Majesty's Order in Council of April 1st, 1881, Fleet Surgeon William Rogerson White, C.B., has been placed on the Retired List, with permission to assume the rank of Deputy-Inspector-General of Hospitals and Fleets (dated July 17th, 1905).

DR. A. C. HOUSTON has been appointed Director of Water Examinations, Metropolitan Water Board, at a salary of £1,000 per annum.

DR. P. H. PYE-SMITH, F.R.S., and Professor J. Rose Bradford, F.R.S., have been elected Vice-Chairmen of the Committee of the Medical Members of the Senate and the Physiological and Laboratory Committee respectively in connection with London University.

Mr. H. J. HUTCHENS has been selected as the Demonstrator of Bacteriology at the University of Durham.

DR. H. W. LANGLEY BROWNE, has been elected chairman of the Council of the British Medical Association for the ensuing three years in the place of Mr. Andrew Clark, whose term of office has expired.

A SCHOOL for Mothers has been recently founded in Madrid by the Marquis and Marchioness de Casa-Torre. The medical director is Dr. Ulecia, who has charge of a dispensary for sick and weakly children.

DR. MICHAEL WARNER, the well-known American physician and an old friend of Dr. Osler, has recently died, and it has been found that he had all his books containing accounts against patients destroyed so that they should not be pressed for payment.

A HANDSOME memorial has recently been erected on the highway near Sidmouth, South Devon, to the memory of the late Dr. T. Gilbart Smith. The memorial, of blue granite, is in the form of a seat, with the following inscription: "Thomas Gilbart Smith, a succourer of many. Thus closed a noble life spent in the service of his fellow men; he never turned his back on duty, but faithful to his motto, "Dare and do," remained undaunted to the end. On this spot at half past nine o'clock, after watching the glorious sunset of August 3rd, 1904, Thomas Gilbart Smith, M.D., F.R.C.P., fell dead from his bicycle."

THE next session at King's College Hospital will commence on Tuesday, October 3rd, when Professor T. Clifford Allbutt will distribute the prizes and give the opening address on Medical Education in London.

THE Chester Town Council yesterday appointed Dr. Albert E. Thomas, assistant medical officer of Stepney, and formerly assistant medical officer of Woolwich, to be Medical Officer of Health for Chester at a salary of £500 a year in succession to Dr. Kenyon, who had held the post for more than thirty years.

THE *Army and Navy Gazette* of July 22nd contains the following announcement: "Some changes in the *personnel* of the Royal Army Medical College may shortly be expected. We understand that the professor of clinical and military medicine, Colonel K. MacLeod, I.M.S., retired, will vacate the appointment and be succeeded by Colonel David Bruce, C.B., F.R.S., R.A.M.C. Then the professor of military surgery, Surgeon-General W. F. Stevenson, C.B., R.A.M.C., retires at the end of this month and will, in all probability, be succeeded by Major C. G. Spencer, R.A.M.C., whose claims and qualifications stand very high, he being an M.D.Lond., and F.R.C.S.Eng. Further, in January next, Lieutenant-Colonel R. H. Firth, R.A.M.C., Professor of Military Hygiene, will vacate his appointment."

The Quatercentenary of the Royal College of Surgeons, Edinburgh.

[FROM OUR OWN CORRESPONDENT.]

THE quatercentenary celebration of this College, the ancient Corporation which first saw the light in the year 1505—the year of Knox's birth—was held on July 20th and 21st, and passed off throughout with the greatest success. The occasion was itself an historic one, the hosts for the time being guaranteed an hospitable reception for their guests. Few cities have greater natural advantages where such functions are concerned, and the one uncertain quantity—the weather—was all that could be desired, brilliant sunshine and warmth enabling the large numbers of people who were present at the various social functions to attend them in the greatest comfort. The official and other guests of the College and the non-resident Fellows for the most part arrived on the Wednesday, when the celebration proceedings began by a private reception, of those on whom it was proposed to confer the Honorary Fellowship, held in the College of Surgeons.

The actual commemoration proceedings were inaugurated by a religious service

IN ST. GILES' CATHEDRAL,

with which, in the pre-Reformation days the Barber-Surgeons of Edinburgh were intimately associated. In their first charter they tell how they maintained as the Church of "Sanct Geill," an altar for the honour of God, "and Sanct Mongow, oure patrone" by donation of a weekly penny, while in the present day the College aided in the restoration of the building by putting in a stained glass window in the clerestory. The commemoration service was conducted by the Rev. Dr. Cameron Lees and the preacher was the Rev. Dr. W. P. Paterson, Professor of Divinity in the University of Edinburgh, who delivered an address on the philosophy of human suffering. The honorary Fellows, delegates from learned and official bodies, assembled with the Fellows of the College of Surgeons in the Hall of Parliament House, and at eleven o'clock the academic procession entered St. Giles', to the strains of a specially composed march by the organist. First came the President, Sir Patrick Heron Watson, accompanied by the vice-president, Sir Halliday Croom. Next appeared the Hon. Fellows elect, representing most of the foreign nationalities, wearing diverse robes, uniforms and decorations, among them being Dr. John Playfair, President of the College of Physicians of Edinburgh, who brought up the rear of the Hon. Fellows elect. Next in order were the Bishop of Edinburgh, the Lyon King at Arms, the members of Parliament for the City, and the Representatives of the four Scottish Universities, preceded by their maces. After this came the main body of the College of Surgeons clad in their robes of dark blue, with light blue stoles adorned by white lace straps and tassels. Following on the academic procession came the arrival of the St. Giles' clergy, and after they had taken their places the service was begun by the singing of the 100th Psalm. Professor Paterson's sermon was from St. John, chapter 9, verses 1 to 3—"And as Jesus passed by, He saw a man who was blind from his birth, and

His disciples asked Him, saying, Master, who did sin, this man or his parents, that he was born blind? Jesus answered, neither has this man sinned, nor his parents, but that the works of God should be made manifest in him." At the outset he alluded to the ancient connection between the College of Surgeons and the church in which they were now worshipping, though the link between them had been broken at the Reformation, the old pledge in the surgeons' "Bill of Supplication" was redeemed by gathering within the same walls to pay homage to a greater God than Him they then ignorantly worshipped, and by imploring His continued benediction upon the institution which they created for the advancement of His kingdom. Apart from this link there was reason enough that the long-established and intimate relations between the healing art and the Christian Church should be prominently recognised at a celebration in which the present asserts its kinship and continuity with the past. It was true that at certain periods the Church attempted to obstruct the march of science and retarded to some extent the development of a rational system of medicine; but as an offset to this it must be remembered that amid the shocks and losses of the Middle Ages the Church was the chief custodian of the scientific legacy from antiquity, which saved the world from intellectual bankruptcy, while the enthusiasm of humanity which had supplied the moral dynamic of the medical profession in the modern western world had chiefly been engendered by the religion which adored in a Good Physician God made manifest in the flesh, and which proclaimed the infinite value of every human being as made in the image of the eternal God. The central topic of the discourse was then reached—the problem of human suffering. The preacher contrasting the old-world idea that it was sent as a penalty, with the Christian view that a world of disease was a world of opportunity, and that it created for man the possibility of doing works like unto those which had their spring in the wisdom and magnanimity of their Father in Heaven. Christ's remarkable saying in their text as to the chief end of suffering, found its most obvious application in the use of medicine and surgery. A grim necessity, as Hippocrates said, was the mother of the healing art. In the work of responding to the imperious summons of distress and suffering, the human mind had discovered and matured its latent powers, and entered on a course of brilliant discovery—work in which every age and grade of civilization took a share according to its capacity. To the preacher it seemed as important to consider whether, apart from the necessity whcih suffering laid upon man to question the basis of things, the edifice of science in anything like the design and proportions that they knew it, would have existed on earth at all. In conclusion, Dr. Paterson next considered how suffering had reacted on man's moral nature and pointed out that the chief tributary of the religious life of mankind had its sources in the region of sickness and in the valley of the shadow. Microscopic views of things and short views of history might cloud and overshadow the sight of the hand of God, and the perception of the impress of the designing mind, but the universe as a whole was too deeply saturated with wisdom, cosmic processes too cunningly framed, the interest in human history too surprising to make it conceivable that the higher teleology would not permanently command the assent of sufficiently instructed and thoughtful minds.

Luncheon by the Town Council.

After the commemoration service in St. Giles' the company to the number of about a hundred adjourned to the Council Chambers, where the principal guests and office-bearers of the College and others were entertained to luncheon by the Corporation. After the loyal toasts, the Lord Provost proposed "The Royal College of Surgeons," offering to the College, and to the guests who had honoured the capital with their presence, a most cordial welcome. On his right hand he had one whose name was a household word in Edinburgh, Sir Patrick Heron Watson, than whom there was no better friend, no better medical adviser, and no kindlier heart in the city. On his left he had the President of the Royal College of Surgeons of England, and they were very proud to have him with them. On his right again he had the President of the College of Surgeons of Ireland. They might differ on the question of Home Rule, but this city was his home for the time being. To these, to Major-General Keogh, representing the Army, and to Mr. Ellis, representing the Navy, to the illustrious foreigners who were sitting at the board beside them, to one and all, in the name of the Corporation, he offered hearty welcome. They were very glad indeed to recognise the debt of gratitude which they owed to the College of Surgeons, and, on the other hand, he thought the College owed gratitude to the city for its incorporation. It was a fact that the City of Edinburgh granted the first charter to the College of Surgeons, and gave it the support which was necessary for its well-being; he was not going to mention how it was supported—he supposed they would not like that now—but they had all been humble in their lives and had had small beginnings. None of their foreign visitors would deny, notwithstanding the long existence of the University of Paris, to which the Scots had been deeply indebted, that the College of Surgeons and the University of Edinburgh had been to a very large extent one of the leading schools of medicine in the world. In common they did not tell anybody what they owed; in the medical profession, however, they gave freely to each other all their experience and knowledge, retaining nothing for themselves, but believing it was their duty to do all they could for the welfare of the people at large. Had Jenner or Harvey been commercial men, their discoveries would have been sold at a high price, but the medical profession, happily, did not move on these lines. All knew how much they owed to Pasteur and Virchow—honoured names in the hierarchy of science. In coupling with the toast the name of the President of the Royal College of Surgeons, he said that but for Sir Patrick Heron Watson they would not have had the present Lord Provost in the chair that day.

The toast was briefly replied to by Sir Patrick Watson, and thereafter the proceedings terminated to enable those present to attend the principal function in the proceedings.

The Commemoration Ceremony in the McEwan Hall.

The central features of this ceremony were the presentation of honorary Fellowships to a number of distinguished European and American physicians, and the reception by the College of Surgeons of congratulatory addresses from learned and scientific societies and corporations. The interior of the McEwan Hall has seldom presented a more striking spectacle than on Thursday afternoon: The area was reserved for those more immediately connected with the ceremony—the magistrates and Town Council, clergymen of various denominations, university officials, representatives of the Faculty of Physicians and Surgeons of Glasgow, and the Fellows of the two Royal Colleges of Edinburgh; while the galleries were occupied by the general public, mostly ladies in the brightest of summer garb. By request of the college, most of those invited wore uniform or academic costume, and for once the sterner sex competed on level terms with their sisters and wives; the crimson of the full dress doctor's robe jostling the blue and silver of the surgeons, while the more sombre black and crimson robe of the Edinburgh College of Physicians contrasted with the brilliant yellow facings of their colleagues from Glasgow. Academic hoods in every colour—crimson, red, purple white, blue, green—formed a striking colour picture, while here and there a military or naval uniform caught the eye by its contrast with the robes of peace and learning. The interval of waiting for the arrival of the platform party was filled by an organ recital by Mr. T. H. Collinson, Mus. Bac. (Oxon.). At four o'clock the College mace appeared, followed by Sir Patrick Heron

Watson and the Lord Provost of Edinburgh. The order of procession was as follows :—

The Mace.
The President.
The Right Hon. the Lord Provost of Edinburgh.
The Right Rev. and Right Hon. the Moderator of the General Assembly of the Church of Scotland.
The Right Hon. the Earl of Stair.
The Lord Justice-General.
The Lord Justice-Clerk.
The Senators of the College of Justice.
The Solicitor-General for Scotland.
Lyon King-of-Arms.
The Principal of the University of Edinburgh.
The President of the General Medical Council.
The Select Preacher—The Rev. Prof. Paterson, D.D.
The Right Hon. the Lord Provost of Glasgow.
The Member of Parliament for the Universities of St. Andrews and Edinburgh.
The Member of Parliament for East Edinburgh.
The Right Rev. the Bishop of Edinburgh.
The Most Rev. the Archbishop of St. Andrews and Edinburgh.
The Vice-President.
The Honorary Fellows Elect.
Secretary and Council of the Royal College of Surgeons of Edinburgh.
Ex-Presidents of the College
The President's Chaplain.
The University Court, University of Edinburgh.
The Vice-President, Treasurer, and Council of the Royal College of Physicians of Edinburgh.
The Visitor, Treasurer, and Council of the Faculty of Physicians and Surgeons of Glasgow.
Representatives of the Army and Navy.
Representatives of the University of St. Andrews.
Representatives of the University of Glasgow.
Representatives of the University of Aberdeen.
Representatives of the University of Edinburgh.
Representatives of University College, Dundee.
The Clergy.
The Magistrates of the City of Edinburgh.
The Provost of Leith.
Representatives of Legal Societies.
Representatives of Medical Societies.
Representatives of Scientific Societies.
Representatives of Public Bodies.
Non-Official Guests.

The President of the Association of Diplomates of Scotland, Dr. St. Aubyn Farrer, was officially present at the Quatercentenary. Other representatives of the same Association were the Hon. Treasurer and Dr. David Walsh, the Honorary Secretary.

As soon as the distinguished party was seated, the President delivered an address of welcome to the brilliant assemblage which had responded to the invitation of the College. He remarked that the origin of the Royal College of Surgeons as a corporate body must be traced back to the reign of James IV. of Scotland, who on October 13th, 1506, confirmed by Royal Charter the "Seill of Cause," which a year previously in July, 1505, had been granted to the Barber-Surgeons resident within the Burgh of Edinburgh, by the Provost, Bailies, and Council of the Burgh. There was, however, he said, reason to believe that even prior to this date an organised body of practitioners had already existed in Edinburgh, to whose laudable desire for an accredited position, and for authority to practise and to teach, the College is indebted for its inception. This body, by its energy and indomitable perseverance, met and overcame the difficulties which stood in its way; and when one recalled the comparatively barbarous condition of the country at that time, and the terrible strife by which it was torn, it was impossible to do otherwise than regard with admiration and respect the work which those men were able to accomplish as pioneers of a great cause. Time, continued the President, would fail him were he to venture on a full development of the history of the Royal College of Surgeons of Edinburgh. He also felt that he must refrain from encroaching upon the time which had still to be devoted to the more important duties of that day. In conclusion, he expressed the grateful appreciation of the College, of the generous consideration manifested towards them by the sister corporation—the University of Edinburgh—in according to this meeting the use of the McEwan Hall. In doing so, he could not refrain from expressing the deep sense of regret which all felt in the lamented death of the late Principal of the University, Sir William Muir.

At the close of the address, the Secretary of the College constituted the meeting according to the usual form of the College of Surgeons, by reciting the following prayer, which tradition asserts to have been composed by John Knox:—"O Eternal God, our loving and merciful Father in Christ Jesus—Seeing we are convened to treat of those things which concern our calling: We beseech Thee, O Lord, to be merciful to us, and give us grace to proceed therein without malice, grudge, or partiality: So that the things we do may tend to the glory of God, the weal of our vocation, and the comfort of every member of it: Through Jesus Christ, our only Lord and Saviour. Amen."

The Honorary Fellowships.

Following on this came the ceremony of admitting the Honorary Fellows. The promoter, Sir Halliday Croom, Vice-President of the College, submitted a short account of the circumstances of the career of each of these, who were the selected representatives of international surgery. As the Fellow-Elect mounted the platform steps the organist played a few bars of his national hymn, he received the right hand of Fellowship from the President, who then presented him with his diploma, while the officer of the College robed him in the gown of his new dignity. The admission was completed by the signature of the College Roll. All the recipients of the Fellowship were heartily applauded; it was perhaps noticeable that the French, Japanese, and American names were greeted with the loudest cheers, but of all the names mentioned, that of Baron Lister came in for the chief ovation. The following Honorary Fellowships were conferred :—

Professor v. Eiselsberg.—May I, said the promoter, introduce Anton, Baron v. Eiselsberg, Hofrath and Professor of Surgery in the University of Vienna. Amongst his more important publications are his contributions to our knowledge of the thyroid gland and of the elimination of pyogenic organisms by the skin. He studied under Billroth, and in 1893 was appointed to the chair of surgery at Utrecht; two years later he succeeded Braun at Königsberg, and has proved himself a worthy follower of the great Billroth.

Professor Fuchs.—No one occupies a higher place in ophthalmic surgery than Ernst Fuchs, the distinguished professor of Ophthalmology and Director of the First Division for Eye Diseases on the Allgemeines Kraukenhaus, Vienna. His reputation is world-wide, and he is a recognised authority on the pathology of the eye. Famous as a teacher, he is the author of a standard work on diseases of the eye, which has been translated into almost every language. I ask you to confer the Fellowship on him *in absentia.*

Professor Saxtorph.—Silvister Saxtorph, of Copenhagen, has held many important posts in Denmark, amongst them Surgeon to his Majesty the King of Denmark; he was appointed Professor of Surgery in 1894, and made a Knight of the Order of Dannebrog in 1898. He has contributed many papers to learned societies, especially on subjects connected with disease of the urinary tract.

Professor Guyon.—F. C. Felix Guyon, Professor in the Paris Faculty of Medicine, is a foremost exponent of genito-urinary surgery; he is a member of the Academy of Science and the Academy of Medicine, and is the recognised leader of the Parisian School of urinary surgeons. I ask you to confer on him the Fellowship *in absentia.*

Professor Lucas Championnière.—M. Just Lucas Championnière was one of the first European surgeons to come to study in Edinburgh under Lister; one of his earliest books was on antiseptic surgery, while he is best known by his writings on hernia, and the treatment of fractures by massage.

Professor Poncet.—No one among the provincial French surgeons stands higher than M. A. Poncet, Professor of Surgery at Lyons, who is famous from his work on bone diseases, affections of the bladder, and actinomycosis. He succeeded Ollier in the Chair of Surgery, and operated on the late President Carnot when he fell a victim to the assassin. I beg that the Fellowship be conferred on him *in absentia*.

Professor Segond.—It is a special pleasure to present a gynæcological specialist in Dr. Paul Segond, Paris, who is a distinguished operator, teacher, and writer, and whose clinical and pathological work has been recognised as of the utmost value. No one has a higher position than Dr. Segond, who is a typical representative of Parisian gynæcology.

Professor Terrier, member of the Academy of Medicine and Professor of the Surgical Clinique of the Faculty, a celebrated surgeon not only in practice but as contributing largely to surgical literature. The honorary Fellowship was conferred *in absentia*.

Professor von Bergmann.—Among the many distinguished surgeons of Germany, no one stands higher than he. Beginning as assistant at the Surgical Clinique at Dorpat, he served under Wagner through the Bohemian war, and under Billroth and Volkmann in the Franco-German War, in which he saw the siege of Paris. In the Russo-Turkish war of 1877–8 he was present at the siege of Plevna, and since 1882 he has been the chief apostle of the famous Berlin School of Surgery, standing at present in the forefront among German surgeons. I ask you to confer the Fellowship *in absentia*.

The list of honorary Fellowships will be concluded in our next issue.

British Medical Association.

Seventy-Third Annual Meeting, July 24th to 28th.

[FROM OUR SPECIAL CORRESPONDENT.]

Second Article.

The Leicester Meeting has been a distinct success, well attended, rich in hospitality and social gatherings, and fruitful in scientific work. Leicester is a clean, active, progressive town, a focus of business enterprise and an excellent example of wise municipal government. Every member received a copy of a dainty "Guide to Leicester and Neighbourhood," produced under the auspices of the Local Executive Committee of the Association. The enterprising firm of Burroughs Wellcome and Company also presented an elegant little handbook to every visitor on "Leicester Medical Lore." Excellent arrangements were made for the comfort and convenience of those attending the meetings. The members' card contained a good map of the town. The reception room was centrally situated in the Y.M.C.A. buildings, and here the Council met and the business meetings were held. The Sections gathered in the various rooms of the admirable Technical Schools, and here also was located the very attractive and well-arranged Pathological Museum. The Annual Exhibition, which was fairly representative, was held in the Drill Hall and Magazine Square, and was well attended. The general arrangement of rooms for members, visitors, ladies, and representatives of the Press was good. The annual service was held in St. Martin's Church on July 25th, at 5 o'clock, and was well attended, the Right Rev. the Lord Bishop of Birmingham delivering the sermon. A Roman Catholic service was also held at the same time.

The meetings of the Council and the gatherings of the representatives took up much time during the first few days, but under the new constitution the great body of members seem to evince but little interest in the business duties of the annual conference. The chief event affecting the future of the Association was the decision to attempt to secure a Royal Charter, thereby giving additional powers and gaining release from undesirable restrictions the working of which was not clearly recognised when the new Constitution was adopted.

The Address of the President, Mr. George Cooper Franklin, F.R.C.S., was delivered on the evening of Tuesday, July 25th, in the Royal Opera House, and dealing to some extent with the medical history of Leicester, was well received. A number of foreign guests and Colonial delegates were received, and the Association's Gold Medal of Merit was presented to Sir Constantine Holman, M.D., and Mr. Andrew Clark, D.Sc., F.R.C.S.

The Address in Medicine was delivered on Wednesday, July 26th, by Henry Maudsley, M.D., LL.D., F.R.C.P.; and the Address in Surgery by Mr. Charles John Bond.

The Nineteenth Summer General Meeting of the Irish Medical Schools' and Graduates' Association, which now numbers 856 members, was held on Wednesday. There was a large attendance of members. In the absence of the President, Sir William Whitla (Belfast), who wrote to express his regret at being unable to be present, Dr. Alfred Freer, as the senior foundation member present, was voted to the chair. The Chairman called on Dr. Stewart to address the meeting in reference to the question of the monopoly of honorary hospital appointments in England. He detailed the efforts that had been made in four cases successfully, to have the exclusive rule repealed which restricted these appointments to those holding the diplomas of two particular colleges. He said that there was prominent in the English character the love of justice, and that when the governors of the institution in which the restrictive rule existed had it brought home to them how unfair it was to put obstacles in the way of those holding such high qualifications as the F.R.C.S.I. and M.R.C.P.I., they gladly carried out the principle of the "open door" and repealed the obnoxious rule. But the difficulty was the expense of bringing the facts of the case under their notice. He (Dr. Stewart) was glad, however, to say that, with the prospect before them of a large accession of new members, the Council had determined to enter soon upon another assault on a monopoly fortress and he was sanguine of the same success as had attended similar efforts at Bristol, Hastings, Brighton, and elsewhere.

On Thursday morning, the National Temperance League gave their annual Breakfast, which is now officially recognised and is undoubtedly one of the best attended and most enjoyable functions of the meeting. The Annual Dinner was held in the evening in the County Assembly Rooms.

On Friday night, July 28th, Professor William Stirling delivered a popular lecture on "Fatigue and Repose."

During the week special meetings were held in connection with the New Sydenham Society, the Irish Medical Schools' and Graduates' Association, the Continental Anglo-American Medical Society, and the United Kingdom Police Surgeons' Association.

A number of very attractive and largely attended garden parties were given. On Wednesday, July 26th, the Chairman of the Leicester Infirmary gave a garden party in the Infirmary grounds, and this afforded excellent opportunity for inspecting the admirable new out-patients' department and the recently opened wing containing well-equipped operation theatres.

On Thursday, July 27th, garden parties were given at the County Asylum, and at Humberstone Hall, the residence of Mr. Maurice Levy, M.P.

On Friday, July 28th, Mr. and Mrs. Samuel Faire gave a garden party at Glenfield Firth.

Various receptions, entertainments, and evening fêtes were held in the evenings.

During the week many factories and municipal and other works were open for inspection.

On Friday, July 28th, at the invitation of the Duke of Rutland, a party visited Belvoir Castle.

Saturday, July 29th, was devoted to excursions and members visited Buxton, Haddon Hall, Chatsworth, Matlock, Castleton, and Charnwood Forest.

A number of members also availed themselves of the kindness of the Leicestershire County Cricket Club and were present at the contest between Leicestershire and Derbyshire.

It should also be mentioned that the enthusiasts of the links were well provided for.

The Local Committees are to be congratulated on the results of their labours. "The Annual Picnic" has come and gone, and now there remains pleasant memories, the renewal of old friendships, the formation of fresh bonds and we may venture to hope a quickening of the spirit of fellowship and goodwill throughout the Association.

The next meeting is to be held in Toronto in Canada.

The Work of the Sections.

Although no discovery or startling announcement of conspicuous scientific value can be placed to the account of the Leicester meeting, the discussions held and the various papers read in connection with the different sections have done no little to stimulate and encourage individual workers, and something to advance medical science and improve the healing art.

There were twelve sections; the attendance in some few was fairly good, but generally speaking the members participating were, to say the least, not numerous. In one sparsely attended section we found the select few engaged in smoking. It is much to be regretted that the scientific work of the Association should be so neglected. While elaborating the machinery for professional protection and trade union, it is most desirable that the scientific spirit should be maintained and be afforded adequate means for expression.

Medicine.

The Discussions in the Medicine Section attracted good gatherings. Sir Lauder Brunton discoursed on the treatment of sleeplessness and pain; Dr. Howard Tooth dealt with the pathology, diagnosis and treatment of various forms of acute meningitis; and Professor Julius Dreschfeld opened the discussion on the diagnosis and treatment of cardiac degeneration apart from valvular disease. No epoch-marking announcement was forthcoming, but much serviceable material was presented and many valuable facts and opinions focussed and fixed. The greater part of the time was devoted to the consideration of the above subjects and only a very few papers were presented.

Surgery.

The Surgery Section was generally well attended. Mr. B. G. A. Moynihan's introduction to the discussion on the surgical treatment of non-malignant diseases of the stomach, was a thoroughly optimistic presentation, and gave rise to a free expression of opinion from many well-known members. The discussion on the treatment of malignant disease of the rectum was opened by the President of the Section, Sir Charles Ball. A number of papers were also read.

State Medicine.

This Section attracted many enthusiastic students of so-called preventive medicine. The much-disputed subject of hospital isolation for infectious disease was dealt with by Dr. George Wilson; sanatoria for the poorer consumptives was discussed by Dr. L. A. Weatherly, Dr. Kelynack, Dr. T. D. Lister, Dr. Nathan Raw, and others. Dr. Kelynack's paper on "Alcohol in Relation to National Vitality," gave rise to an important discussion, and it was unanimously resolved to recommend the Council to appoint a Special Committee to enquire into the alleged influence of alcoholism in lowering national vitality.

Bailie W. F. Anderson opened a discussion on "Infants' Milk Depots." "What is Notifiable Diphtheria?" formed the subject of a discussion carried on in conjunction with the Section of Laryngology, and was opened by Dr. P. Watson Williams. Several papers of public interest were also read in this section.

Industrial Hygiene and Diseases of Occupation.

The discussions held by this section, dealt with physical deterioration, anthrax, and accident and poisoning reports.

Laryngology, Otology, and Rhinology.

On this occasion friends and foes formed a triple combine and much interesting discussion ensued. Dr. William Milligan opened the discussion on the lines of treatment in preventing acute middle-ear suppuration from becoming chronic. The treatment of tuberculous disease of the larynx was dealt with by Dr. Jobson Horne, Dr. Habershon, Dr. Harold Barwell, and others. A number of instructive papers were also read.

Navy, Army and Ambulance.

This Section attracted but a small number of members, but several papers dealing with many practical matters were read and considered.

Obstetrics and Gynæcology.

Professor Wertheim opened the discussion on "The Diagnosis and Treatment of Cancer of the Uterus"; and a consideration of the treatment of albuminuria and eclampsia occurring in pregnancy was opened by Dr. Robert Boxall. Many members took part in these important discussions, including several "lady practitioners." A number of useful papers were also presented.

Ophthalmology.

Mr. Walter H. H. Jessop opened a discussion on intraocular tuberculosis; and Mr. E. Treacher Collins pointed out the various capsular complications which may occur after cataract extraction. A number of papers were also read..

Psychological Medicine.

Several matters of much interest received consideration in this select section, such as "The Clinical Study of the Heredity of Insanity," "The Occupation and Environment as Causative Factors of Insanity," and "Prognosis in Mental Disorders."

Pathology.

The President, Dr. F. W. Mott, opened a valuable discussion on the "Relationship of Heredity to Disease," in which Dr. Archdall Reid and others took part. Several papers of interest were read.

Dental Surgery.

This Section was presided over by Mr. Morton Smaill, who delivered a short introductory address. A useful and lengthy discussion "Toothache, Neuralgia and Remote Affections of Open Origin" took place, in which many specialists and members participated. Several papers were read and considered.

Tropical Diseases.

The subjects of tick fever, tropical diseases of the skin, and sprue, and hill diarrhœa were dealt with, and a number of papers were also read.

The Annual Exhibition of Foods and Drugs, including prepared foods, chemical and pharmaceutical preparations, medical and surgical instruments, antiseptic dressings, and appliances, books, diagrams, &c., was a thoroughly representative "show," and although several old firms were conspicuous by their absence. the exhibition was a thorough success and well patronised. A special feature of the show was the good collection of motor cars and accessories.

We shall hope to deal with the more important exhibits in our next issue.

Correspondence.

THE ANGLER'S HOLIDAY.

To the Editor of The Medical Press and Circular.

Sir,—So many readers of your journal are disciples of old Walton, that they will be gratified to hear of the admirable arrangements made this season for the protection of ***amateur angling*** by the Lucerne municipality. Since November last all such fishing has been limited to lines, restricted to certain months annually, and always only authorised by special permits. The cost of these permits is most reasonable. running from 10 francs for one month to 40 francs for nine months. The number of lines for each boat for lake fishing is limited to two, and the sizes of fish strictly defined; all caught smaller than certain dimensions to be immediately replaced in the waters. All particulars about fishing regulations can be obtained from the Official Inquiry Bureau, Lucerne.

This "new departure" of the liege-lords of Lucerne adds to the already numerous attractions of their beautiful city. Its great accessibility, exquisite situation. superb surroundings, multiplicity of excursions and entertainments on land and water, abundant and varied scope of hotel, pension, and apartment life, mingling together here of the antique and the modern, have made Lucerne an unsurpassed centre for continental summer tourists. I am, Sir, yours truly,

W. G. M.

RECTAL FEEDING.

To the Editor of the Medical Press and Circular.

Sir,—With reference to your remarks on the above subject in your last issue, may we be permitted to draw attention to the experiments made by Hoppe, and published in the *Munich Med. Wochenschrift*, No. 51, 1904? Hoppe's Enemata were made up of sanatogen, and it is interesting to note that the percentage of absorbed material ranged from 77 to 81, an,—to our mind,—unusually high figure. It would seem from these experiments that albumen, as present in sanatogen, holds an important place as a means of feeding by the rectum. So far we are not aware of any experiments having been made with sanatogen as an enema here in England, but we think that those interested in the subject would find it worth their while to make a trial in that direction.

We are, Sir, yours truly,
The Sanatogen Company.

83, Upper Thames Street, London, E.C.
July 27th.

TREATMENT OF RINGWORM.

To the Editor of the Medical Press and Circular.

Sir,—In your annotation on School Ringworm, it is stated that "under the most skilled treatment the disease lasts from six months to two or three years or more." I have had much experience in the treatment of ringworm at the Plymouth Public Dispensary. Of late years I adopted the treatment of the late Dr. Illingworth: he suggested the use of the biniodide of mercury.

My practice was to closely cut away the hair for a distance of a quarter of an inch or more surrounding each bald spot, and on such cleared space, and even further around, to apply the solution suggested by Dr. Illingworth. I always applied it myself on the first visit of the child, that the mother might see how to act. I allowed the solution to soak well into the skin and follicles, rubbing it into the space with a brush.

The results were most satisfactory. It appeared to me often that the disease was arrested in a week or a few weeks.

Dr. Illingworth's solution was made of hyd. biniodid. 1 drachm; sodii iodid., 2 drachms; aq. dest, to 1 oz. This made a solution of one in eight. In practice I diluted it to one in a hundred, more or less. Dr. Illingworth said that one in a thousand was adequate.

The solution was applied once in twenty-four hours. I carefully instructed mothers to omit it for a day or two if any redness or soreness followed its use.

I hope that Dr. Illingworth's suggestion, if tried in great schools, may confirm the value of his practice. A general treatment with malt extract or cod-liver oil was also carried out if indicated.

I am, Sir, yours truly,
William H. Pearse.

Plymouth.

INFANT MORTALITY AND QUACK NOSTRUMS.

To the Editor of The Medical Press and Circular.

Sir,—The proprietors of Woodward's Gripe Water do not furnish an address, and I have failed to obtain the name of the medical officer alluded to in the following advertisement which appears in the daily papers:—"Infant mortality is mainly due to intestinal troubles. I am thoroughly satisfied that 'Woodward's Gripe Water' is a safe and reliable remedy."—A Medical Officer of Health (name given privately). Sold by all chemists, grocers' stores, price 1s. 1½d."

Would it not be possible for one of our medical defence societies to ascertain the identity of the gentleman in question and to communicate it to the Medical Council. Medical readers do not need to be told that the cure of "intestinal troubles" in infancy by a medicine would approach the miraculous, and they do not believe in miracle-mongers who work by secret remedies for gain alone. The amount of harm that may be done when dealing with infantile complaints by reliance upon drugs when the true cause lies in improper food and feeding is deplorable; but no doubt some people find consolation in the fact that the proprietors of the Gripe Water, at any rate, must be making a large income out of their nostrum, else they could not afford to spend thousands a year in advertisements.

I am, Sir, yours truly,
An Obscure Practitioner.

July 26th, 1905.

A "VACANCY IN ALGIERS.

To the Editor of The Medical Press and Circular.

Sir,—My attention has been called to certain advertisements and circulars emanating from a gentleman in holy orders *sine cura*, soliciting applications from English medical men provided with a French qualification to practise in France, to fill an alleged vacancy at Algiers. This wholly unauthorised proceeding seems to be giving rise to a very natural misunderstanding in regard to myself, and I therefore deem it wise to ask your permission to state that I have been in practice at Algiers for two years past and propose returning there in due season.

I am, Sir, yours truly,
Alfred S. Gubb, M.D.(Paris), M.R.C.S., &c.

Aix-les-Bains, July, 1905.

Obituary.

EDMUND WADAMS, M.R.C.S.ENG., L.S.A.

Malvern has lost one of her oldest practitioners in the person of Dr. Edmund Wadams, after a long illness. He graduated M.R.C.S. in 1843, and settled in Malvern in 1845, and for 37 years was Medical Officer, under the Upton Board of Guardians, for Malvern and Powick districts. On his retirement he was the recipient of a testimonial, Dr. Wadams, who gave up his practice in 1895, introduced to Malvern the Tallerman hot air treatment for gout and rheumatism.

CHARLES HOOPER, M.R.C.S.ENG., L.S.A.

We regret to record the death of Mr. Charles Hooper, who died at Aylesbury on July 16th, aged 75, after a long illness. He was born at Buntingford, where his father, Dr. John Hooper, was in practice, and was educated in King's College, London, and took the diplomas of L.S.A. and M.R.C.S.Eng. in 1852 and 1853 respectively. He first went to Aylesbury as house surgeon to the present Royal Buckinghamshire Hospital, and at the time of his death had been in private practice for upwards of fifty years. He held the post of Medical Officer of Health to the Aylesbury Urban Council for a long time and for many years he was one of the honorary surgeons to the Royal Buckinghamshire Hospital, Chairman of the Aylesbury division of the South Midland branch of the British Medical Association, and an Associate of the Sanitary Institute.

Literature.

PROF. MAYO ROBSON ON THE TREATMENT OF CANCER. (a)

The reprint of the Bradshaw Lecture, with additions, 1904, is "a protest against the fatalistic tendency to delay, and the senseless running after false gods," in the treatment of this fell disease. Its tone is hopeful in that the author, with his unrivalled experience, expresses the conviction that cancer, if discovered early and thoroughly removed, is by no means so refractory to treatment as is usually thought. Frankly sceptical as to the results of recent research into the causation of cancer, the author confesses himself equally ignorant of the predisposing conditions, but he does not despair of our ultimately elucidating these obscure problems. It is something to have established the fact that cancer is by no means restricted, as was even recently held, to the human race; indeed, its widespread incidence obliges us to study it with a wider mental aperture, so to speak. The infectivity of cancer may now be regarded as proven, and the recognition of this fact has distinctly influenced surgical conduct, especially in the direction of preventing auto-infection.

(a) "Cancer and its Treatment." By A. W. Mayo Robson, D.Sc., F.R.C.S., Senior Vice-President of the Royal College of Surgeons of England. London: Bailliere, Tindall and Cox. 1905. Price 3s.6d.

The author accepts the assumption of "pre-cancerous conditions," and advocates what we may term prophylactic operations, and his position is justifiable on the ground that we are not in possession of any means of determining the precise moment when benignancy merges into malignancy; indeed, his view is only the logical conclusion of the doctrine of early operation. This has an important bearing on the surgical treatment of chronic gastric ulcer, since this appears so frequently to pave the way to subsequent malignant growth.

The trend of experience based on statistical results may be expressed in a few words: "In many cases cancer can be prevented by treatment in the pre-cancerous stage; that, even when cancer has developed, if it be seen early and thoroughly removed, it is frequently a curable disease; and lastly, even in the later stages, much may be done by surgical treatment to give real relief."

Medical News.

Dismissal of Judgment Against Sir Patrick Heron Watson.

LAST week the House of Lords gave judgment on the appeal of Sir Patrick Heron Watson. The facts of the case were shortly as follows:—An Edinburgh lady, the respondent in the appeal, was pursuer in an action of separation and aliment brought against her husband, on the ground of alleged cruelty, which was decided against her. Sir P. Heron Watson made certain statements in the witness-box which the respondent alleged were slanderous, these statements having been prior to the trial, and with a view to giving evidence communicated by the appellant to the lady's husband and his agent and counsel. The question raised in the appeal was whether the averment of the respondent that the statements made in the witness-box were previously communicated to the respondent's husband and his agent and counsel formed a ground of action against the appellant. The Lord Chancellor, in delivering judgment, said: In this case an eminent medical man was consulted. He gave no communication to strangers or to persons outside the litigation. The communication was made to the counsel and solicitor, and in the circumstances it was the duty of the person who was to become a witness to tell the truth and the whole truth, otherwise the precognition would be worthless. He therefore moved that the appeal be allowed, and that the judgment given against Sir P. Heron Watson should be reversed, with costs. The result of the decision is that the immunity from action in respect of evidence in a court of law extends to the statement made to those conducting the litigation as to what is the nature of the evidence to be given.

Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society was held on July 21st. There were present the Chairman, Dr. de Havilland Hall, Dr. J. Rundley James, Dr. J. Pickett, Dr. Frederick S. Palmer, Mr. H. P. Symonds (Oxford), Mr. F. S. Edwards, Dr. F. J. Allan, and Dr. J. B. Ball. The accounts presented showed, as is usual at this time of the year, a great falling off in the number of sickness claims, but though fewer in number, the recent cases have been more than usually serious and it seems probable that several additions will have to be made to the chronic list. A large sum is paid away annually to members who, under the liberal arrangements of the Society, are entitled to annuities, generally one hundred guineas a year, till aged 65. The cost of this was fully allowed for when the Society was founded and the reserve now amounted to about £200,000. Prospectuses and all particulars of Mr. F. Addiscott Secretary, Medical Sickness and Accident Society, 33 Chancery Lane, London, W.C.

The Royal University of Ireland.

THE following regulations for the holding of the M.B., B.Ch., B.A.O. Degreees Examinations have been adopted, to come into force at the October examinations:—

1. That the Examinations in Medical Pathology and Surgical Pathology be separated, 25 marks being assigned to each.

2. That the Pass examination shall be held in all respects in the same manner as heretofore.

3. That the further examination for Honours shall be exclusively a written examination, and only those candidates can be admitted to it who, upon their answering at the Pass Examination are specially recommended for admission by the examiners.

4. That Honours shall be awarded not on the examination as a whole, as heretofore, but in the following groups:—

(*a*) Medicine, theoretical and clinical, including therapeutics, mental diseases, medical jurisprudence, sanitary science, and medical pathology.

(*b*) Surgery, clinical, and operative, including the use of instruments and appliances, ophthalmology and otology, surgical anatomy, surgical pathology.

(*c*) Midwifery and diseases of women and children.

5. The candidates qualified to present themselves for Honours may select one or more of the following groups:—

6. The Honours paper shall be set on the day following the announcement of the results of the Pass Examination. They shall consist of—

(*a*) A paper on medicine and medical pathology.

(*b*) A paper on surgery and surgical pathology.

(*c*) A paper on midwifery and diseases of women and children.

Each paper to be of two hours' duration, and 100 marks to be assigned to each.

7. The Honours in each group shall be awarded, taking into account the entire number of the marks obtained by the Candidate at the Pass Examination in that group, together with the marks obtained on the Honours paper.

8. The Exhibitions shall be awarded, having regard to all the marks obtained both at the Pass and the Honours Examinations.

British Pharmaceutical Conference.

THE forty-second annual meeting of this body was opened at the Hotel Métropole, Brighton, on Tuesday, July 25th. This is an organisation distinct from the Pharmaceutical Society, and is solely concerned in "the encouragement of pharmaceutical research, and the promotion of friendly intercourse and union amongst pharmacists," whereas the Pharmaceutical Society is a statutory body charged with the administration of the Pharmacy Acts, and the examination and registration of those who desire to be registered under these Acts. The Conference was received by the Mayor and Mayoress at the Royal Pavilion on Monday evening, and on Tuesday morning the president, Mr. W. A. H. Taylor, F.I.C., F.C.S., of London, delivered an address, chiefly devoted to "The Standardisation Question," and the processes of the British Pharmacopœia. Thereafter satisfactory reports of the position of the Conference were submitted, and the reading and discussion of communications resulting from researches. The meeting concluded on Thursday last. The Conference was attended by nearly 300 pharmacists from all parts of the United Kingdom, and several colonial chemists were among the number.

London School of Tropical Medicine.

THE following is a list of candidates who have passed the examinations at this School from May to July:—Dr. J. T. C. Johnson (Colonial Service), Surgeon E. R. Stitt, U.S.N., Dr. D. Mackinnon (Colonial Service), Dr. E. F. Wood (Colonial Service), with distinction; Dr. W. L. M. Goldie; Dr. J. S. Smith (Colonial Service); Dr. S. G. Allwood; Dr. E. V. Croke (Colonial Service); Dr. A. R. Wellington; Dr. E. Hopkinson, Dr. J. T. Waite, Dr. W. D. Inness, Dr. N. Beaumont (Colonial Service); Dr. H. G. Waters; Dr. T. E. F. Toovey (Colonial Service).

PASS LISTS.

Royal College of Surgeons, England.—New Members.

AT an Ordinary Meeting of the Council held on July 27th, the following candidates having passed the required examinations, were admitted members of the College:—John H. D. Acland, Hugh W. Acton, James E. Adler, Frederick D. Atkins, Frederic C. J. Baker, George L. Birch, Herbert A. Bodkin, William C. P. Bowater, John F. Boyd, Gerald A. Bradshaw, Walter Bremner, Cuthbert G. Bromne, John Bryan, Ronald Bryden, Launcelot T. Burra, Henry Catling, Durie A. Chamberlain, Thomas C. Clare, Colin Clarke, Cecil E. Clay, Arthur R. Clayton, James E. Collins, Vyvian Colmer, Hugh P. Costobadie, Louis Courtauld, James H. Crawshaw, Malcolm O. Cruickshank, Frederick S. Davies, Langford G. Davies, Joseph B. Dawson, George F. Denning, Herbert A. De Pinna, Clive T. Edmunds, Ray Edridge, Thomas S. Elliott, Christopher Elliott, Hugh R. Evans, Percy Farrant, William H. Fleetwood, Gerald E. Friend, James G. Gibb, Edgar H. Good, Harry T. Gray, Leonard Gray, John P. Griffin, Arthur D. Griffith, Charlton R. Hall, George Hamilton, William H. Hastings, Montague L. Hine, Edward T. Holland, Herbert S. Hollis, Alfred G. Jones, Grenville P. Jones, Herbert S. Knight, Tikiri B. Kobbekaduwa, John E. Lascelles, Harold L. Laws, Rowland P. Lewis, William S. Livock, Reginald C. McDonagh, Arthur H. Macdonald, John T. Macnab, Thomas M. McPherson, Arthur H. Miller, Echlin S. Molyneux, George E. V. Morris, Gerald H. Morris, George S. Morse, Harry M. Newport, Francis M. Newton, John S. Pearson, Wilfred J. Pinniger, Theodore C. Pocock, Harold E. Priestley, Ireton G. Pritchard, Harold E. Rawlence, Harold W. Read, Vivian E. Ridewood, Ellis J. Roberts, William G. Robertson, George M. Sanderson, Ernest L. Sandiland, Robert P. Sephton, Ernest H. Shaw, Hugh G. Sherren, Lionel Shingleton-Smith, John W. Simon, Kanwar S. Singh, Harold S. Sington, Clare O. Stallybrass, Edward J. Sunnucks, Robert A. Thomas, William R. Turtle, Cecil Vosper, Gwilym D. Watkins, Herbert A. Watney, Walter Welchman, Arthur G. Wells, Trevor H. Wilkins, William J. Wilkinson, William W. Williams, James M. Wyatt.

New Diplomates in Public Health. Granted in conjunction with the Royal College of Physicians:—Jackson A. Atkinson, Robert J. Blackham (Capt. R.A.M.C.), Neil Campbell, Herbert E. Corbin, Louis Courtauld, John W. Fox, James A. Glover, Walter L. Goodridge, Hermann L. Hamilton, Edwin C. Hayes (Capt. R.A.M.C.), Henry Holt, Percy S. Lelean (Capt. R.A.M.C.), Norman F. MacLeod, James Meek (Major R.A.M.C.), John W. Myler, F.R.C.S., John Nightingale, James F. Powell, John E. Robinson, Eugene D. Townroe.

Licences for the Diploma in Dental Surgery were granted to George Herbert Parkinson and Stanley Arthur Piper.

The statement of accounts for the year ending June 24th, with the certificate of the auditors attached thereto, was submitted and approved. It was determined to add Uppingham School to the list of institutions recognised by the Examining Board in England for instruction in chemistry, physics, and biology.

The Secretary reported that the First Congress of the International Society of Surgery will be held in Brussels, September 18th to 23rd.

Mr. Henry Morris was re-elected a Member of the Executive Committee of the Imperial Cancer Research Fund.

The subject for the Heath Scholarship Essay for 1906 is "Injuries and Diseases of the Arteries, Veins, Capillaries, and their Treatment." The essays must be typed or printed and sent in to the Professor of Surgery not later than March 31st, 1906.

Royal College of Surgeons, Edinburgh.—New Fellows.

AT a meeting of the College held on July 26th, the following gentlemen, having passed the requisite examinations, were admitted Fellows:—Lewis Beesly, L.R.C.S.E., Edinburgh; Alexander Brownlee, L.R.C.S. L.R.C.S.E., Edinburgh; Harold Branson Butler, M.R.C.S.Eng., Guildford; Duncan Macnab Callender, M.B., Ch.B., Edinburgh; Naunidh Rai Dharmavir, L.R.C.S.E., Mexborough; Augustus D'Souza, L.R.C.S.E., Edinburgh; James Ferguson, Duncan, M.B., Ch.B., Edinburgh; James Forrest, M.B., Ch.B., Blackpool; Alfred Thomas Gavin, M.B., C.M., Dunaskin; Bharat Chandra Ghosh, L.R.C.S.E., Punjab; Frederick Charles Hitchins, M.R.C.S.Eng., St. Austell, Cornwall; Mathew Holmes, M.B., Ch.B., Edinburgh; Robert James Irving, M.B., C.M., Norwich; Samuel Jesudasan, M.B., C.M., London, N.; John Arnold Jones, M.B., Ch.B., Manchester; Edwin Malcolm Lithgow, M.B., Ch.B., Edinburgh; Samuel Harvey M'Coy, M.R.C.S.Eng., St. Catharine's, Ontario; John Stewart Merrillees, L.R.C.S.E., Auburn, Melbourne; John David O'Donnell, L.R.C.S.E., Mysore, India; George Benjamin Pemberton, M.B., Ch.B., Edinburgh; Charles George Webster, L.R.C.S.E., Captain I.M.S.; and Charles Peterson Weekes, M.R.C.S.Eng., Sutton, Surrey. The Medal and set of books forming the Bathgate Memorial Prize, presented to the College by Colonel William Lorimer Bathgate, in memory of his late father, William McPhune Bathgate, Fellow of the College, were awarded to Mr. Peter Gorrie, 3 Cameron Park, Edinburgh.

Conjoint Examinations in Ireland.

AT the special examination for the Diploma in Public Health the following gentlemen passed:—Aylmer William May, M.D. Univ. Dublin; Wyndham Malan Gratton Guinness, M.D., Univ. Dublin, and Major William James Taylor, M.B., R.U.I., R.A.M.C., with honours.

Final Examination.—Archibald Crawford Adams, Israel Allaun, Thomas Somers Blackwell, Robert Andrew Brown, Thomas Walker Browne, William Wallace Boyce, William Edward Brunskill, Raymond Bury, William Charles Carson, Samuel Creighton Clarke Foster Coates, Patrick Vincent Dolan, Rodolphus Whittaker Harper, Patrick Edward Hayden, John Marcus Hayes, Henry Hosty, Luke McGuinness, Joseph James McNelis, and Henry Edward Redmond.

Third Professional Examination.—R. Adams, C. Anderson, Miss H. Beamish, R. M. Bronte, W. Carroll, M. E. Cussen, F. Coates, W. J. Deighan, R. Galgey J. Grace, F. M. Hewson, P. M. Keane, G. H. Kinmouth, E. Montgomery, P. Mullany, P. J. McKevett, D. O'Flynn, J. P. O'Kane, O'C. O'Reilly, H. J. Perry J. T. Reardon, W. C. T. Robey, and C. Sheahan.

MR. H. O. BISCHOFFSHEIM, founder of the London Ambulance Service, has generously offered to provide free an electric motor ambulance and similar vehicles later on.

PRINCE CHRISTIAN OF SCHLESWIG-HOLSTEIN presided at a meeting to found a new infirmary, to be named, by permission of his Majesty, "King Edward the Seventh's Hospital and Dispensary for Windsor and District."

THE *London Gazette* last week announced that the King, by Letters Patent, confers the dignity of a Knight of the United Kingdom upon the undermentioned gentlemen:—Mr. Philip Sydney Jones, M.D., of Sydney, in the State of New South Wales, and Mr. Edmond Sinclair Stevenson, member of the Medical Council of the Colony of the Cape of Good Hope.

Notices to Correspondents, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when eturning proofs.

DR. H (Bedford).—You can certainly charge for advice by telephone, there is no valid reason why telephonic consultations should stand on a different footing to a letter. It is perhaps wise to make it clear at the time that a telephonic consultation is to be considered as an ordinary professional service.

INSURANCE.—(1) Total abstainers were not always regarded with favour by Insurance Companies. One of the first members of a total abstinence society founded in 1810 was refused at ordinary rates as abstinence was supposed to shorten life. (2) To decline a case outright because there is a discharge from the ear is not in practice at most insurance offices, the tendency being more and more to accept impaired lives at an increased rate. Bone disease of the inner ear, however, must be treated with the utmost caution.

MEDICAL INSPECTOR.—It has been shown both in Germany and England that women telephonists have nerve troubles transitory or chronic, most frequently paræsthesia, hyperæsthesia, or vaso-motor troubles in the regions of affected nerves.

CORONER (Grimsby).—The whole subject of suicide has been ably dealt with by Dr. Wynn Westcott, Coroner for the N.E. district of London. He states that London has fewer suicides in proportion than any other town in the world, standing against Paris with only 90 per million, while that city has 400 per million.

DR. F. (Berwick).—During June 37 cases of lead poisoning and 4 of anthrax were reported under the Factory and Workshop Act, but no cases of mercurial, phosphorus or arsenical poisoning.

COLONIAL M.D.—Those suffering most severely from mosquito bites are generally run down in health. Eucalyptus in the bedroom will keep them away, and the old-fashioned "blue bag," which owes its healing properties to a small amount of ammonia, is not to be despised as an application for stings.

THE Recorder at the Old Bailey, London, last week remarked to a doctor who took the oath in the Scottish form with uplifted arm: "It is a much more sanitary and a much more solemn oath than our own, and in my opinion it ought to be made universal."

DR. HODGSON.—Your communication came to hand as we were "at press." We hope to have space for it in our next.

MR. R. H. H.—It is a matter about which we can offer no opinion.

DR. F. S. M.—The alterations are chiefly of detail and do not affect existing regulations. These will be classified and arranged in our forthcoming "Educational Number."

Vacancies.

Cheshire County Asylum, Macclesfield.—Junior Assistant Medical Officer. Salary £140 per annum, with apartments, board, and washing. Applications to the Medical Superintendent.

Roxburgh District Asylum, Melrose, N.B.—Assistant Medical Officer. Salary £140 per annum, with board, rooms, &c. Applications to Medical Superintendent.

Royal Lancaster Infirmary.—House Surgeon. Salary £100 per annum, with residence, board, attendance and washing. Applications to the Secretary.

North-Eastern Hospital for Children, Hackney Road, Bethnal Green, E.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to T. Glenton-Kerr, Secretary.

West Riding of Yorkshire.—Assistant to County Medical Officer. Salary £250 per annum. Applications to Trevor Edwards, Clerk to the Committee, County Hall, Wakefield.

Bath Royal United Hospital.—Resident Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to J. M. Sheppard, F.C.I.S., Secretary.

Royal Victoria Hospital, Bournemouth.—A House Surgeon. Salary £100 per annum, with board and lodging. Applications to the Secretary.

Noble's Isle of Man Hospital and Dispensary, Douglas, Isle of Man.—Resident House Surgeon. Salary £90 a year, with board and washing. Applications to Richd. D. Gelling, Honorary Secretary, St. George's Chambers, Athol Street, Douglas, Isle of Man.

Parish of St. Marylebone.—District Medical Officer.—Salary £90 per annum. Applications to Henry T. Dudman, Clerk to the Board, Guardians' Offices, Northumberland Street, Marylebone Road, W.

Salop Infirmary, Shrewsbury.—House Surgeon, Salary £100 per annum, with board, washing, and residence. Applications to Joseph Jenks, Secretary.

Aldershot Urban District Council.—Medical Officer of Health and Superintendent of the Isolation Hospital. Salary £300 per annum. Applications to W. E. Foster, Clerk, Municipal Buildings, Aldershot.

Royal College of Surgeons in Ireland.—Senior Demonstrator in Anatomy. Salary £100 per annum. Applications to the Registrar. (See Advt.)

Appointments.

EARLE, R. A. L.S.A.Lond., Medical Officer and Public Vaccinator for the Weston-super-Mare, District of the Axbridge Union.

FRAMPTON, TREVETHAN, F.R.C.P., M.R.C.S., Clinical Assistant to the Chelsea Hospital for Women.

HANCOCK, W. J., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Stalybridge District of the county of Chester.

HILL, R. A. L., M.R.C.S.Eng., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Wimbledon District of the county of Surrey.

LAPAGE, C. P., M.D.Vict., Medical Officer to the Out-patient Department of the Manchester Children's Hospital.

McGAVIN, LAWRIE H., F.R.C.S.Eng., Surgeon to the In-patients on the staff of the *Dreadnought* Hospital, Greenwich.

PATERSON, MARCUS S., M.B., B.S., M.R.C.S., L.R.C.P., Medical Superintendent of the Brompton Hospital Sanatorium, Frimley, Surrey.

SWAINSON, G. M. G., F.R.C.S., Assistant Surgeon to the North-Eastern Hospital for Children, Hackney Road.

THOMAS, L. KIRKBY, M.R.C.S., L.R.C.P.Lond., Anæsthetist to the Birmingham and Midland Hospital for Women.

TYLECOTE, FRANK EDWARD, M.D.Vict., Medical Registrar to the Manchester Royal Infirmary.

Births.

BURGESS.—On July 29th, at Lode House, Upwell, Norfolk, the wife of J. G. Burgess, L.S.A., of a daughter.

ROBINSON.—On July 27th, at 1 Rue d'Aguesseau, Paris, the wife of Leonard Robinson, M.D.Edin., M.D.Paris, of a daughter.

THOMPSTONE.—On July 25th, at Marsh Parade, Newcastle, Staffs., the wife of Sydney W. Thompstone, F.R.C.S., M.R.C.P., D.P.H., Principal Medical Officer Northern Nigeria, West Africa, of a daughter.

Marriages.

DAWSON—BOSTOCK.—On July 26th, at the Church of St. John the Divine, Bedford Hill, Balham, Alfred Ernest Knight Dawson, son of the late Edward Dawson, M.R.C.S., L.S.A., of Finchingfield, Essex, to Florence Agnes, eldest daughter of Decimus Crosthwaite Bostock, of Hawkhurst, Terrapin Road, Upper Tooting.

DUPONT—FINDLEY.—On July 25th, at the parish church of St. George's, Bloomsbury, John Munro Dupont, M.D., to Anna Townsend Findley, youngest daughter of the late George Washington Townsend, of Newburgh and New York, U.S.A.

HODGSON—BONE.—On July 27th, at Downhill, Glasgow, Charles Hodgson, L.R.C.P., M.R.C.S.Eng., Leyburn, Streatham, second son of Henry Hill Hodgson, Anerley, to Margaret Mitchell, only daughter of Robert Bone, M.B., C.M., and Mrs. Bone, 31 Elgin Terrace, Glasgow.

URE—DAY.—On July 28th, at St. Marylebone Parish Church, John Francis Ure, M.A., B.C.I., (Oxon.), Barrister-at-Law, son of the late Dr. John Ure, of York, to Isabella (Kitty) eldest daughter of the late Dr. C. H. Day, of the Indian Medical Staff, and of Mrs. Day, Darjeeling, India.

WEEKS—STEVENS.—On July 27th, at St. Cuthbert's, Philbeach Gardens, Harold Weeks, M.B., of 44 Scarsdale Villas, Kensington, to Mary Stevens, only daughter of the late Walter J. Stevens, of Kobé, Japan.

Deaths.

BULLOCH.—On July 30th, at Ragaz, Switzerland, Rosamond Majorie, wife of George J. Bulloch, of London, and younger daughter of James Frank Holland, M.D., St Moritz, aged 24.

CONDON.—On July 19th, at Glasnevin, Dublin, Lieut.-Col. James Hunt Condon, M.D., Indian Medical Service, R.L., in the 73rd year of his age.

GRINDROD.—On July 29th, at Gaytonhurst, Heswall, Cheshire, Cyril John Wedemeyer Grindrod, M.R.C.S., L.R.C.P.Lond., fifth son of the late Rev. W. Grindrod, vicar of Alne, Yorkshire.

McLINTOCK.—On July 30th, at Church Stretton, Shropshire, Hannah, widow of the late J. R. McLintock, M.D., aged 63.

MORRIS.—On July 30th, at Hamilton House, Leamington, Joseph Morris, M.R.C.S., L.R.C.P. L.S.A, aged 70 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, AUGUST 9, 1905. No. 6.

Original Communications.

THE DIAGNOSIS OF TUBERCULOUS LARYNGITIS IN ITS EARLY STAGE. (a)

By HAROLD BARWELL, M.B.LOND., F.R.C.S.ENG.

Laryngologist, Mount Vernon Hospital for Consumption; Assistant Surgeon, Metropolitan Ear, Nose, and Throat Hospital; Consulting Surgeon for Throat and Ear Diseases, Cripples' Home for Girls; Clinical Assistant to the Throat Department, St. George's Hospital.

GENTLEMEN,—I want to impress upon you, and I should like to impress upon the entire profession, the great value of the inspection of the larynges of consumptives at regular intervals as part of the routine management of such cases, and for the following four reasons :—

Tuberculous laryngitis, though principally a complication of the advanced stage of phthisis, is by no means uncommon at all periods of consumption ; it frequently causes no symptoms whatever until it is comparatively far advanced ; it is often curable at its onset, much more so than when the larynx is extensively involved ; and, finally, if neglected, it causes one of the most painful forms of death which a man may suffer. To my mind these are unanswerable arguments that it is the duty of medical men to examine the throats of consumptive patients as a matter of routine, whether laryngeal symptoms are present or not. This is done here, at the Mount Vernon Hospital, and it is largely to this that I attribute the high percentage of local cures that we obtain ; and if this method were generally followed I am convinced that a great deal of suffering would be prevented.

It is clear, therefore, that the diagnosis of tuberculous laryngitis in its early stage is a subject of great importance, that treatment may be begun when there is a fair chance of cure, for routine inspection without arriving at a diagnosis is naturally useless.

The disease is often most easy to recognise at a glance, but sometimes the diagnosis is extremely difficult. It would seem superfluous to remark that all cases of laryngeal disease in consumptive patients are not tuberculous laryngitis, but a decided tendency exists to diagnose them as such. Nevertheless it is astonishing what a number of other forms of laryngeal disease I see among the consumptive patients in this hospital ; chronic laryngitis and pachydermia are very common in phthisical patients, but I also see a large number of cases of laryngeal syphilis and a sprinkling of other lesions, such as new growths.

There is a very general opinion that pallor of the laryngeal mucous membrane is characteristic of tuberculous laryngitis. This, however, is by no means really the case. Consumptive patients are often anæmic, and then the larynx, in common with the palate, fauces and other mucous membranes, will be pale ; but if the patient be not anæmic, the colour of the larynx is normal, or even reddened from irritation or secondary infection. Tuberculous granulations are usually pallid, and the margins of ulcers are not injected ; the massive swellings of the arytenoid region are often, but by no means always, pale, especially if œdematous. Even then, the unaffected parts of the larynx have no characteristic tint, and very often tuberculous infiltration, especially on the cords, ventricular bands and epiglottis, has a deeply congested red appearance. An anæmic larynx means that the patient is anæmic, and is no proof whatever that the larynx is affected with tubercle.

Tuberculous ulcers are very slow in growth ; the edge is extremely ill-defined and has no surrounding zone of injection ; it is undermined when the ulcer is deep, but tuberculous ulcers tend to spread superficially rather than deeply. The base is set with granulations, and often presents a characteristic yellowish, "speckly" appearance ; in the interarytenoid region these granulations are apt to become exuberant and form large, soft, irregular masses. On healing, there is no excessive formation of scar-tissue, and contraction and deformity are of the slightest.

Laryngeal tuberculosis assumes many different forms, and it will be convenient to discuss their diagnoses separately. Three principal types may be described—the aryteno-epiglottic, the chorditic, and the interarytenoid. The aryteno-epiglottic type of the disease affects chiefly the upper aperture of the larynx ; attacking the arytenoids first, it slowly spreads outwards along the aryteno-epiglottidean folds, until at a later stage it involves the epiglottis. When small, the arytenoid swelling is oval, but when large it assumes a characteristic pyriform or flask-shaped aspect. As the submucous tissue is plentiful here, the swelling may reach a great size and ulceration is rare and occurs late ; the infiltration is bilateral, though one side may be more affected than the other. It is usually pink or red in colour, and is pale if œdematous. This arytenoid infiltration is almost pathognomonic, for no other chronic affection shows this symmetrical swelling. In œdematous laryngitis this region is much swollen, but where the disease is obviously acute, the onset is sudden, fever is high, and the rest of the larynx is in a state of acute inflammation.

(a) A Post-graduate Lecture, illustrated by drawings and cases, delivered at the Mount Vernon Hospital for Consumption, on July 13th, 1905.

Again, the arytenoid region is a not uncommon site for the formation of a gumma; the tumour, however, is unilateral, and more firm and solid in appearance; it usually breaks down to form a deep "crateriform" ulcer, with a sharply punched-out edge surrounded by a zone of injection, the base of which is thick and hard, and is often covered by a yellow mass of necrotic tissue. The amount of pain is no criterion, for a gumma on the arytenoid may cause the most severe dysphagia.

A malignant growth on the arytenoid region is unilateral, firm and hard, red and angry looking; it ulcerates early, and is more likely to resemble syphilis than tubercle.

The epiglottis is very rarely attacked in the early stage of tuberculous laryngitis, and the rest of the larynx is usually already extensively diseased. In contradistinction to syphilis, the laryngeal surface is always the most severely affected; extensive destruction of the epiglottis, without much disease in other parts of the larynx is nearly always due to syphilis. The so-called "turban-shaped" epiglottis, combined as it always is, with arytenoid infiltration, is absolutely pathognomonic of tubercle, but it is quite rarely seen.

When the tuberculous process begins by attacking the vocal cords, the diagnosis may be much more difficult. The lesions are most marked on the posterior half of the cords and on the cartilaginous glottis, and assume a great variety of forms. In the earliest stage there may be merely a diffuse redness of the cords indistinguishable from that produced by catarrhal laryngitis. Simple laryngitis is very common in consumptive patients, and is due partly to the strain of coughing, and partly to the irritation of the sputum; such cases should be treated promptly by rest and soothing inhalations, lest tuberculous infection supervene. As a rule, even at its onset, tuberculous infiltration of the cords shows certain peculiarities which enables the diagnosis from simple laryngitis to be made with certainty. Even when there is simply redness of the cord, it is generally decidedly more advanced on one side than the other, and, indeed, is not uncommonly confined to one cord; this unilateral congestion is never due to catarrh, but always to tubercle, syphilis, injury or early malignant disease. As a rule, too, tuberculous infiltration produces more than a simple redness and swelling. A speckly red appearance, described by Lake as "chorditis granulosa," is very characteristic; at other times the cord is converted into a firm pink nodular, tumour-like mass, or, again, it may resemble a smooth, broad band of red granulation-tissue, which adheres somewhat to its fellow as the cords separate after phonation. These three appearances are common enough, and are easy to distinguish from simple catarrh. Small erosions may sometimes be seen in simple laryngitis, but definite ulceration does not occur.

When catarrhal laryngitis has been excluded, the diagnosis must next be made from laryngeal syphilis. Both secondary and tertiary syphilis often attack the vocal cords; as in tuberculosis, the affection is often most marked on one side and it may produce simple congestion, or a nodular or smooth mass of infiltration; the scattered red specks of "chorditis granulosa" are peculiar to tuberculosis. The part of the cords affected is of great importance for diagnosis; for it is especially here that the rule holds good that syphilis attacks the anterior region, while tuberculosis is most marked at the posterior two-thirds. Isolated lesions on the anterior half of the cords are very rarely tuberculous, but the converse does not hold good to the same extent, for syphilis may produce ulcers about the vocal processes while the rest of the glottis is unaffected; cicatricial thickening about the anterior commissure is fairly common in syphilis and very rare in tuberculosis. A plentiful formation of scar-tissue is apt to result from syphiltic lesions and may produce a web across the glottis. Tuberculous ulcers, as I have said already, have very ill-defined edges, so that their exact limits are difficult to determine, there is no surrounding zone of infection, and the base is covered by pale speckly granulations; syphilitic ulcers, on the other hand, have sharply-cut edges, surrounded by a very definite hyperæmia, and the base is smooth and flat. In addition to the laryngoscopic appearance, other points will aid the diagnosis. Thus the character of the voice is very important, and the diagnosis may sometimes almost be made from this as soon as the patient enters the room. The hoarse voice of tuberculous laryngitis is a weak one, and the vocal effort is small, as opposed to the more energetic and harsher "raucous" voice of syphilis where the waste of air is obviously considerable. In syphilitic laryngitis, lesions may often also be seen on the fauces, palate or pharynx, and such are very rare in tubercle. The history is, of course, of some value, and more especially in relation to the duration of the symptoms; a patient with a history of hoarseness for several years, who has only a small lesion—such as localised ulceration—of the cords, more probably owes his troubles to syphilis than to tuberculosis.

The following case, which I saw recently, illustrates some of these points very well.

An unmarried girl, æt. 25, was sent to my out-patient clinic by the physician. She had undoubted phthisis, and had been hoarse for four weeks. There were no external signs of syphilis, and no reason whatever to suspect it, except that the voice had a peculiar rough, grating quality. The mouth and fauces were healthy; both cords were uniformly reddened, and on each, at the junction of its anterior and middle third, was a minute ulcer with a smooth yellow base and sharp edges surrounded by a small but definite zone of infection. These points were sufficient to establish the diagnosis of syphilis, although no history could be obtained and there were no other signs of the disease. I gave her mercury, and in a week the ulcers were nearly healed without local treatment, and in another fortnight the larynx was normal.

A small number of cases of tuberculous laryngitis occur in elderly people, and when the lesion is chorditic in type the resulting hoarseness or loss of voice may give rise to a suspicion of malignant disease which may be extremely hard to disprove. Epithelioma is most common on the vocal cords and appears here—(1) as a warty growth, (2) as a diffuse infiltration, or (3) simply as a unilateral congestion, it is rare under forty years of age, and is seldom found on the cords in women. Only the rare tuberculous tumours imitate the warty form, but the other two may be very similar in appearance to the type of tuberculosis attacking one cord; however, in the latter affection, the disease is less often absolutely confined to one cord without any lesion of any other part of the larynx. Early and marked loss of mobility, and a heavy delayed movement or "dragging" of the cord, are very suggestive of malignancy, as is also a dirty-white opaque appearance of the growth. The diagnosis is not often difficult, but that it is so at times the following case, recorded by Lake, will show :—

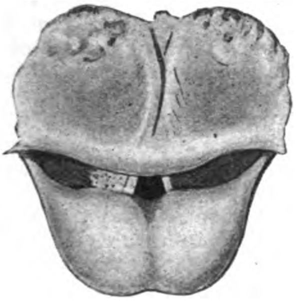


FIG. 1.

The patient, a man, æt. 51, was seen in June, 1898. He had had a cough during the winter, and had suffered from gradual loss of voice for six months before. The right cord was thick, swollen and greyish-white; later there was immobility of this cord, and the vocal process became prominent and reddened. The case was thought to be probably malignant, exploratory laryngotomy was suggested but refused. Six months later, a portion of the growth was removed and examined, and the report sent to Dr. St. Clair Thomson, under whose care the patient then was, ran as follows :—"The growth is decidedly suspicious, containing a mass of epithelial cells; but it is impossible to give a definite opinion on so small a piece of material, the relations of which to the deeper structures are unknown." Early in 1899, tubercle bacilli were, for the first time, found in the sputum; and the patient died, in June, 1899, of pulmonary phthisis.

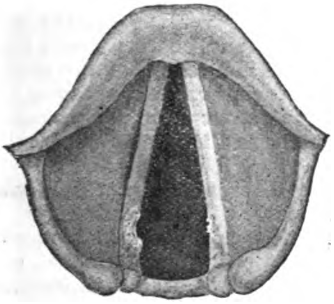
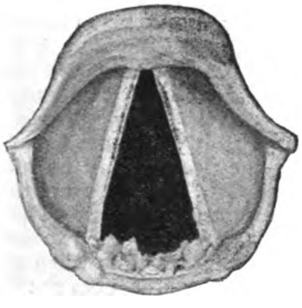


FIG. 2.



FIGS. 1, 2 AND 3.—Varieties of tubercular disease.

In the third common form of this disease, the interarytenoid region is principally affected; and the lesions often closely resemble those of the pachydermatous form of chronic laryngitis. Pachydermia laryngis, more or less marked, is very common in consumptive patients; Gougenheim, indeed, believes that most cases of pachydermia

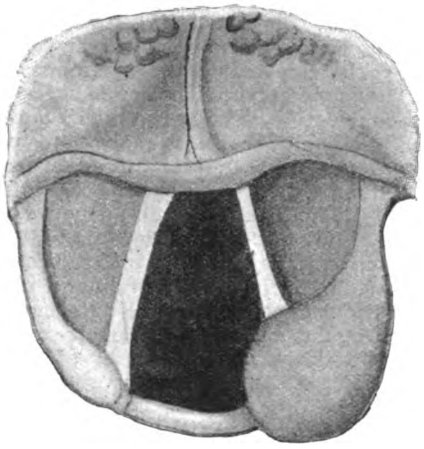


FIG. 4.—Syphilitic disease (tertiary) of left arytenoid and ventricular band.

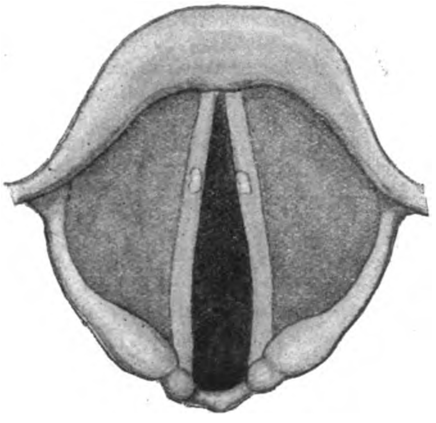


FIG. 5.—Early syphilitic ulceration (secondary) of vocal cords.

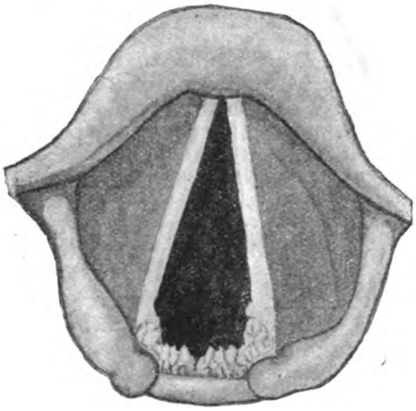


FIG. 6.—Pachydermia laryngis.

are due to tuberculous infection. Pachydermatous thickening is often seen in the posterior commissure in cases of chronic suppuration of the accessory sinuses of the nose, and I believe that the irritation of the sputum from phthisical lungs may produce the same effect, without there being of necessity any infection of the larynx by the tubercle bacillus. Pachydermia affects chiefly the cartilaginous glottis as far forwards as the vocal processes; the thickenings are symmetrial, and begin in the angle between the arytenoid and the posterior commissure, usually leaving a depression in the middle line of the latter; they are regular in arrangement, firm, and of an opaque white colour, and are smooth, or show only a finely-crenated edge like a cock's-comb; small erosions may be seen, but true ulceration does not occur. On the other hand, tuberculous infiltration in the interarytenoid space looks soft, and has a peculiar semi-translucent appearance; the outgrowths are markedly irregular and often asymmetrical; they are frequently merely the edges or granulating base of an ulcer which, seen foreshortened in the mirror, may be difficult to recognise. Distinct ulceration and large papillary excrescences in this region are practically diagnostic of tuberculosis. Sometimes, instead of an irregular mass of granulations, a single papillary outgrowth is found; this is also very characteristic of tubercle, for true papillomata hardly ever occur in this region alone, or on the posterior third of the vocal cord; I have found giant-cells in the base of such a growth after removal.

From lupus, the diagnosis is in reality not difficult. It is seldom primary in the larynx, the lesions being also to be seen on the face and palate. The characteristic nodules are always present; the colour is a rather deep red; if ulcers are present they are well-defined with a dry indolent base, spreading slowly in one part and cicatrising in another, and forming a large amount of scar-tissue. The disease has a marked predilection for the epiglottis, and pain is absent or very slight.

The diagnosis from leprosy also presents no difficulty. In this disease, the skin is always affected as well; the characteristic appearance of the larynx is that of rounded knobs, firm and not translucent, of a pale pink colour, looking like skin rather than mucous membrane. There is no pain, the chief symptom being hoarseness, but dyspnœa occurs when the infiltration is extreme.

I have dealt with the subject chiefly from the point of view which most concerns the practitioner, that is, where the patient is known to be consumptive; and it will be seen that the diagnosis, though often easy, is at other times decidedly difficult, but can usually be made by careful attention to detail. When the throat-symptoms are the first to attract attention, the signs of phthisis in the chest, the temperature chart, and the presence of bacilli in the sputum are important points; but it should be remembered that, though the presence of pulmonary phthisis be proved, it does not follow that the laryngeal disease is necessarily tuberculous. Again, the physical signs in the chest often become masked to an extraordinary extent when the larynx is affected.

When the larynx is attacked primarily, or very early in the course of the pulmonary disease, the affection is apt to take on atypical forms; for instance, tuberculomata and thyroid perichondritis are comparatively frequent in such cases.

In cases where a rapid diagnosis is urgent, as when malignant disease is suspected, other methods may be employed. The scrapings of an ulcer, or, better, sections of a punched-out piece of tissue, may be examined microscopically and stained for tubercle bacilli; cultures may be made from such material, or a guinea-pig may be inoculated.

The use of Koch's tuberculin has been advocated, and is no doubt of value, in the diagnosis of obscure cases. In adults, 1 milligramme is injected; if the patient be tuberculous, the temperature should rise in ten or twelve hours to 102° or 104° F. The larynx, if affected, will show a local reaction. If there is no reaction, 5 milligrammes should be injected two days later; and 10 milligrammes may be given after a further similar interval, and repeated once again. If the result is still negative, tuberculosis is disproved.

In view of the good results obtained by the active treatment of tuberculous laryngitis in its early stage, I hope that more careful attention will in future be given to its diagnosis, before urgent symptoms attract the notice of patient and doctor; for then the disease is too often advanced beyond the reach of curative treatment.

A PLEA FOR THE NERVE ORIGIN OF CANCER.

By ROBT. HUGH HODGSON, M.D.

The rush to discover the specific microbe of cancer seems to me to be very much like a maid turning over and marvelling at the cinders under the grate, and trying to discover how they made the fire. I think it far more probable that cancer is of nerve origin and that any specifically shaped bodies which may be attributed to it are the result of the disease and not its cause. The reasons for looking upon cancer as of nerve origin are numerous, and I think more feasible. Let me, then, for argument's sake, call cancer a nerve disease with local manifestations. No one will deny that cancer is more frequent in the latter part of life, the time when human beings have less reserve nerve energy. Cancer is more common where there is transitional tissue, with its less typical characteristics, and where the nerve direction is dubious as to what type to assume. It is certain that all tissues of the body are controlled by nervous influence, whether histologists are able to demonstrate the existence or otherwise of nerve elements therein. That cerebral disease may and does cause disease in every structure of the body without any necessarily known continuity of nerve tissue is acknowledged, and it may reasonably be assumed that the various tissues of the body are designed and controlled by nerve influence. The fact that sarcoma, a disease nearly allied to cancer, occurs mostly in the young at a time when nerve energy is supposed to be at its best, does not detract from the value of age as an element in the argument that cancer is of nerve origin, but rather strengthens it, for in sarcoma we find an uncontrolled growth more nearly simulating normal tissue, whereas in cancer the growth is more of a degenerate type, due to age decline of nerve vitality. In sarcomatous subjects we may generally detect a want of sharp delineation of features and form due, as I submit, to deficiency of nerve influence, although the patient may be young. Injury to a part interferes with the nerve control of that part, and long arrest of due nerve control permits growth undestined to serve any special purpose and lacking conformity with any typical tissue. With youth there is more regenerative power, hence we have generally sarcoma in youth and carcinoma in advancing years. The increase of cancer in the present day points to its nerve origin, for now it is necessary to make greater calls upon the brain and nerves generally which, with their consequently diminished reserve store of energy are less able to resist long irritation. People cannot move more quickly, be constantly on the alert to take advantage of an opportunity or to avoid a danger without a greater expenditure of nerve energy. Women suffer more frequently than men by reason of their being more subject to exceptional trials at times when their nerves are fairly exhausted. In other words so long as the part, or that immediately adjoining, is continued to be nourished by the circulation, so long will growth go on and so long as the nerves of that part maintain their functions accurately, so long will that growth be controlled, shaped, and adapted to the special purposes of that part, and conversely when the nerves of a part have become by long continued irritation exhausted or paralysed, so in proportion to the amount of injury will be the unrestricted and purposeless growth. The difference between sarcoma and cancer may be explained by the better circulation of the young. The course of pathological research would appear to be in the chemical analysis of healthy nerve structures, and comparing their elements both quantitative and qualitative with those of nerve tissues in the immediate neighbourhood of, in the near, and at a distance, from the disease. The treatment would naturally be in the direction of increasing the store of nerve force rather than in excitation and exhaustion of what little the patient may have. Removing him from depressing surroundings and encouraging him with the hope of possible arrest of his disease. The consideration whether warm climate is not preferable to cold, the amount and quality of his food; the study and exhibition of those drugs which supply food for nerve centres.

OCULAR THERAPEUTICS. (a)

By SYDNEY STEPHENSON, M.B., F.R.C.S.E.

Lecture I.

The general advance in therapeutics that has marked the last few years has been shared in by ophthalmology. It may, indeed, be claimed that in some respects the latter science has led the way, more especially with regard to the principles underlying the local application of remedies. Thanks to the strides of synthetic chemistry, a host of new remedies has been introduced, and although some of these products have not withstood the fire of destructive criticism, yet others have taken a permanent place in the arsenal of therapeutic remedies. There is no organ in the human body better adapted for experimenting with remedies than the eye, since the superficial parts, as the conjunctiva and the cornea, the iris and the crystalline lens, can be kept under close and constant supervision. Not only have new remedies been discovered, but novel methods of applying the older agents have been introduced, as witness the intravenous injection of the soluble salts of mercury.

In the course of the following remarks I shall deal mainly with such things and methods as I have myself used. I have no sympathy with those who look askance at the newer pharmacology. On the contrary, I am convinced that it is the bounden duty of all in a position to do so to try new agents, to endeavour to separate the wheat from the chaff, and to complete their work by publishing with candour results, be they good, bad, or indifferent. "Surely every medicine," said Francis Bacon, "is an innovation; and he that will not apply new remedies must expect great evils." "A froward retention of custome," he continues, "is as turbulent a thing as an innovation; and they that reverence too much old times, are but a scorn to the new."

My subsequent remarks may be considered under two heads:—First, local remedies—that is to say, such as are applied directly to the eye; and secondly, general remedies, including general anæsthesia, X-rays, radium, serum- and organo-therapy, and the treatment of certain diseased states, as syphilis and rheumatism, that are not infrequently associated with affections of the eye.

I. Local Remedies.

It is a matter of familiar knowledge that remedies are applied to the eye in several different ways—as, for example, in liquid, ointment, or powder form. Moreover, as will be explained later, they are nowadays often injected beneath the conjunctiva.

When a drug as atropine is dropped into the eye, dilatation of the pupil is soon observed. By what mechanism does this come about? That the remedy does not act through the circulation is shown by the fact that if it did so it would, when placed in the conjunctival sac of the eye, dilate both pupils. The drug, as a matter of fact, acts by the atropine finding its way by diffusion into the aqueous humour, and thereby acting directly upon the tissues, vessels, and nerves of the iris. The truth of this observation is attested by a famous old experiment. If atropine be employed to dilate the pupil of a dog's eye, and some of the aqueous be withdrawn by means of a syringe, this liquid when placed in the eye of a second dog will dilate the pupil. Remedies which act upon the internal parts of the eye, therefore, when dropped into the conjunctival sac, do so by a process of imbibition, and, as we shall shall see directly, this process may be hastened by certain remedies, particularly by adrenaline and cocaine. Of the conditions which interfere with the imbibition of fluids from the conjunctiva two stand prominently forward—namely (1) increased vascularity of the surface blood vessels, and (2) increased intra-ocular pressure, or "tension," as it is usually called. A good example is acute glaucoma, where in addition to being congested, the tension of the eyeball is materially raised. To endeavour to render such an eye anæsthetic by dropping cocaine into the conjunctival sac as a preliminary to the performance of an iridectomy would be a sheer waste of time, a fact recognised by every practical surgeon. Hence, the operation in question is seldom attempted under such circumstances without the administration of a general anæsthetic, as chloroform.

Some remedies, as antiseptics and astringents, act directly upon the superficial structures of the eye, and this is equally true whether they are applied as liquids, powders, or ointments. Ointments compounded with vaseline and lanoline present certain advantages, especially when the eye is reddened or waters freely, since they keep the remedy of which they are the vehicle longer in contact, as it were, with the parts on which it is desired to act.

Of late years, more especially in France, attention has been paid to the advantages of employing oily collyria—that is to say, the solution of alkaloids, not in water as is usual in this country, but in oil of various kinds. The medium recommended by Dr. Scrini, of Paris, is olive oil, although I have found that most patients upon whom comparative trials are made express their preference for sesame oil. Castor oil may also be used. In this connection it must be borne in mind that the alkaloids themselves, whether atropine, cocaine, or others, must be employed, since the salts of the alkaloids, although freely soluble in water, are but little soluble in oily menstrua. Before the oil is used to dissolve the alkaloid it must be carefully cleansed and sterilised. There are various ways of doing this, but the plan recommended by Delacour is perhaps the best and simplest that can be adopted. It is as follows :—the oil is first well washed with half its volume of strong alcohol, for the purpose of freeing it from fatty acids, and it is then decanted, and, if necessary, filtered. Lastly, it is sterilised by being boiled heated to a temperature of 120° in a sand bath for half an hour. The outstanding advantages of oily collyria are three in number :—(1) they may be kept for many months without undergoing change ; (2) they furnish a most unfavourable medium for the development of micro-organisms or moulds ; and (3) they produce no irritation when dropped into the eye. It has also been claimed (4) that they fail to set up dermatitis in cases where the same alkaloid dissolved in water has done so (*Ophthalmoscope*, 1905). At all events, oily solutions of antropine and of cocaine offer considerable advantages to country practitioners who in the ordinary course of things must be provided with the several agents, even although they may seldom be called upon to employ them.

(a) Lectures delivered June 1905, at the Polyclinic, London.

There is, as I have said, an important way of applying liquids so as to reach the interior of the eyeball, and that is by injecting them beneath the conjunctiva—the so-called subconjunctival injection, for the popularisation of which we are mainly indebted to Dr. A. Darier, of Paris, the therapeutic leader of our speciality. The principle upon which they are based is a sound one, *viz.*, always to apply the remedy as near the focus of disease as possible. This important principle is now becoming widely recognised in general medicine, as witness the injection into the tuberculous lung of guaiacol, and of the salicyl compounds into the blood-stream of those suffering from acute articular rheumatism.

Subconjunctival injection has received more attention abroad than in this country. Many striking cures have been reported. Its actual position, however, in the treatment of disease has not yet been clearly defined, although it has been on trial for upwards of ten years. The most varied substances have been employed for the injections, but the chief are corrosive sublimate, cyanide, or biniodide of mercury, potassium iodide, sodium chloride, hetol, iodipin, and Poehl's physiological salt, which represents the osmotically active constituents of human blood. It seems probable that the precise agent employed is not so important as the liquid menstruum, for it is difficult on any other assumption to explain the cure of a given disease by using several different remedies. It is not quite clear yet how subconjunctival injections act, although it is likely that the irritation they produce causes an exudation from the vessels of the eyeball rich in albuminoids and protective substances from the blood, with the consequence that the aqueous humour becomes strongly hæmolytic.

Indications.—The injections may be employed in many different affections of the eyeball, particularly in those that are scarcely touched by the more usual methods of medication. At the same time it is necessary to insist upon the fact that the method is not one to be adopted without definite indications or in cases that are likely to yield to simpler measures. After all, the injections entail considerable trouble and time on the part of the surgeon, and call for some little fortitude on that of the patient. They are, therefore, not to be adopted without care, thought, and consideration. The indications for subconjunctival injections may be briefly put as follows :—To produce asepsis in infective ulcers of the cornea, notably when accompanied by pus in the anterior chamber of the eye (hypopyon) ; to exert a specific action upon the lesions in syphilitic choroiditis, retinitis, and, more rarely, irido-cyclitis ; to promote absorption in the choroidal lesions of high myopia ; to influence desperate cases of sympathetic ophthalmitis ; and, lastly, to help in the absorption of the subretinal exudation of detached retinæ. There is still another indication, and that is in the corneal opacities left by an attack of keratitis, interstitial or otherwise, where subconjunctival injections render considerable help.

The injections have recently been employed with a view to clearing up the opacities of cataract, incipient or advanced. As yet it would be premature to say anything very definite about the method, although no harm can be done by glancing briefly at what has been accomplished in this direction. A Madrid surgeon-D. Verdereau (*Archivos de Oftalmologie Hispano-Americanos*, October and November, 1904) produced cataract experimentally in rabbits, and then endeavoured to clarify the opaque crystalline lens by the direct injection of a solution of potassium iodide into its substance. The opacity was found to diminish, but, unfortunately, the experiment could not be followed to a conclusion, because severe inflammation came on in the eyes thus treated. In a second series of experiments, he employed subconjunctival injections of the same solution, and found that a distinct effect was produced. Verdereau next applied his experimental results to patients affected with senile cataract. One patient alone had the courage to submit herself to a full course of injections, but the results obtained in that case were truly remarkable, since her sight improved from one-sixth to two-thirds, while the lenticular opacities disappeared step by step with the improvement in sight. Verdereau found a definite improvement in several other patients, even although many of them underwent a single injection only. My own personal experience in this matter may be stated in a few words. During the last three years I have treated by subconjunctival injections several patients who were suffering from choroidal lesions and lenticular opacities. *Pari passu* with the improvement in the choroiditis I have observed lenticular opacities become smaller and in two cases disappear altogether. These experiences encourage me to hope that we may some day be in possession of some remedy that injected beneath the conjunctiva will cause the absorption of lenticular opacities. What is at present a scientist's dream may one day become converted into a sound, a substantial, and a salutary reality.

The Technique of subconjunctival Injections.—The only instrument needed is a small syringe, Pravaz or otherwise, capable of ready sterilisation. Some surgeons introduce a speculum between the eyelids and keep the eyeball in place by means of fixation forceps. This can be necessary only in intractable patients. In young children, the injection is best made after the administration of ethyl chloride. Local anæsthetics, of course, are useless in such young subjects. The conjunctiva is rendered insensitive by means of a drop or two of cocaine (2 per cent.), holocaine (1 per cent.), or stovaine (4 per cent.), the upper lid is raised, and the patient desired to look well down and in. The needle (which should be very sharp) is introduced obliquely beneath the conjunctiva which covers the upper and outer part of the eyeball, between the insertions of the superior and the external rectus muscles, as near the equator as possible. The fluid is then slowly injected beneath the conjunctiva, which rises like a bleb. The needle is then withdrawn, and the little operation is complete. In sensitive people or in those not accustomed to the injection a pad and bandage should be applied and kept in place over night. Pain, chemosis, hæmorrhage beneath the conjunctiva, and swelling of the eyelid may follow the injection, results that depend upon several factors, of which the most obvious are the individual reaction of the patient, the position where the injection is made, and the nature and amount of the liquid employed. The pain produced is perhaps the most serious drawback to these injections, more especially in private practice. But, as pointed out by Darier, pain may be minimised or altogether done away with by adding to the solution for injection a few drops of 1 per cent. or 2 per cent. acoine—that is, di-para-anisyl-mono-phenethyl-guanidine-hydrochloride, to give the substance its full chemical title. Recent investigation by Scrini (*Arch. d'Ophthalmologie*, June, 1905) indicate that the new local anæsthetic, storcise, may be applicable under similar conditions;

One objection urged against subconjunctival medication is that a cicatrix may be produced beween the conjunctiva, on the one hand, and the subjacent sclera, on the other. This is doubtless true if the liquid be injected close to the cornea, but not if practised, as it should be, as far away from the cornea as possible. It is not a little curious that Dr. Deschamps has recently (*Rev. Gen. d'Ophtalmologie*, May, 31st, 1905, p. 222) proposed to avail himself of the production of scar tissue with the idea of so modifying the curvature of the cornea as to correct any regular astigmatism that may exist. For this purpose he proposes subconjunctival injections of sodium chloride at the extremities of the most convex diameter of the cornea, and he claims that by these means it is possible to correct as much as 2D. of astigmatism.

The following rough classification of the local remedies to be now described will render the subject simpler to follow:—

(1) Antiseptics. (2) Mydriatics. (3) Myotics. (4) Anæsthetics and analgesics. (5) Miscellaneous remedies.

I. ANTISEPTICS.

One of the oldest and most efficient antiseptics in eye-work is silver nitrate. Its virtues in that direction were found out by ophthalmic surgeons long before the genito-urinary specialists familiarised themselves with its qualities. "I have sometimes alarmed other practitioners," wrote William Mackenzie, in his famous "Practical Treatise on the Diseases of the Eye," published in 1854 (fourth edition), "by proposing to drop upon the surface of an eye highly vascular, affected with a feeling as if broken pieces of glass were rolling under the eyelids, and evidently secreting puriform matter, a solution of lunar caustic; and I have been not a little pleased and amused at their surprise when, next day, they have found all the symptoms much abated by the use of this application."

In superficial inflammations, which are nearly invariably due to the action of various micro-organisms, silver nitrate has yielded the best results. In bacterial invasions of the conjunctiva, above all, it was until recently indispensable.

The agent, however presents several drawbacks of a somewhat unpleasant nature. These are mainly, if not entirely, due to the nitrate salt with which the silver is combined. I have unfortunately witnessed several accidents, some of a most serious nature, from silver nitrate. For example, a nurse at one of the large Poor-law infirmaries was instructed to apply solid copper sulphate to the eyelids of a child suffering from trachoma. Instead, she rubbed the lining of the lids with pure lunar caustic, with results that may be better imagined than described. When I saw the patient a few hours after the injury one cornea was converted into a greyish slough, and the sight of that eye was practically abrogated. It is gratifying, however, to note that the sight eventually rose to 2-3 normal. Another case fell under my notice a few years ago in the person of a little boy, æt. 9. According to the history, about six weeks before, a somewhat heroic operation for trachoma had been performed upon the lad's eyes. Chloroform had been administered, the trachoma-growths removed with silver nitrate, and the eyes then irrigated with a solution of common salt. The palpebral conjunctiva, when I examined the child, was traversed with cicatricial bands, the lower lids were more or less adherent to the eyeball, and about two-thirds of one cornea was occupied by a curious, greyish-yellow deposit, much like the one spoken of in the case above. V. 1-30 normal. Eventually sight rose to ½ normal. Here are brief details of another case where I myself actually produced a silver opacity of one cornea! A little girl, æt. 4, was under my care on account of ulceration of one cornea, which refused to yield to the ordinary remedies. The intense photophobia induced me to apply, under ethyl chloride, lunar caustic to the ulcer. The consequence was that, although the ulceration was cured, yet its former site was occupied by a dense, slightly-raised, greyish-white deposit, lying beneath the corneal epithelium. Otherwise the eye was free from redness or irritation. An attempt to scrape away the deposit resulted in opening the anterior chamber and the formation of an adhesion between the iris and the cornea, which had to be liberated later by incision. I could quote other instances of more or less severe injuries to cornea or conjunctiva, but enough has been said to show that silver nitrate is an agent which should be employed carefully, if at all, in cases of distempered eyes.

The other drawbacks of silver nitrate include discomfort, irritation, and actual pain, want of penetration, liability to produce local staining, so-called "argyrosis," and in many cases eschars of the mucous membrane. To be quite candid, the fact is that silver nitrate, although invaluable in the hands of those who have learned how to use the remedy, is apt to become a somewhat dangerous weapon if employed without due experience, skill, and discrimination. The knowledge of this fact has led chemists to endeavour to find an agent that shall possess the antiseptic powers of silver nitrate without its undesirable qualities. It has become widely recognised that the clinical value of a silver compound depends upon the amount of contained silver, and that this is modified, often in an undesirable direction, by the other chemical constituents of the salt. The ideal agent, according to Fraenkel, must fulfil the several requirements of not coagulating albumen or of precipitating sodium chloride, of solubility in water, and of not producing pain or of setting up any irritation of the eyes (*Ophthalmoscope*, March, 1904). The list of agents that fall more or less into line with these requirements is a long one, but I shall discuss only protargol, largin, and argyrol, since I have employed the agents named upon a very extensive scale in the treatment of diseases of the eye. A few words of description may be devoted to each product.

Protargol.—This laboratory product contains 8·3 per cent. of metallic silver. Its watery solutions are stable. It is, however, essential that they should be prepared with cold water, since heat causes an irritating by-product to appear, and this may give rise to pain when the protargol is applied to an inflamed eye. The solution is to be kept, like all silver preparations, in amber coloured bottles.

Protargol is now widely employed in external inflammatory affections of the eye, such as blepharitis, acute and chronic ophthalmia, and lacrymal disease. As a lotion for acute catarrhal ophthalmia, a 5 per cent. solution may be used as an eye wash three or four times a day, and the same solution, or a weaker one, in cases where the lacrymal sac is suppurating. In ophthalmia neonatorum, particularly when the gonococcus is the cause (about one-half the cases) something stronger is called for. The conjunctiva may be brushed one or twice a day with a 50 per cent. solution, the eyes being kept clean in the meantime by the frequent use of a 2 per cent. to 5 per cent. solution. Upon the whole, this is one of the best treatments for ophthalmia neonatorum with which I am acquainted.

Has protargol, then, no drawbacks as regards the eye? It now and then causes some little pain, but never anything like that following the application of even a weak solution of silver nitrate. It is possible, as already hinted, that these discomforts may be connected with an incorrect way of preparing the solution. The great disadvantage of protargol, to my mind, is the undoubted fact that it tends to an even greater extent than silver nitrate to cause indelible staining of the parts to which it is applied. It is this most undesirable quality that has induced me to look in another direction for the ideal silver substitute. At the same time, there can be no doubt that, clinically, protargol is an active and efficient agent, and one that can never harm the cornea in whatever strength it is employed.

Largin.—This product contains 11·10 per cent. of silver combined with protalbin. It is soluble in water, and may be used as a 10 per cent. solution in the same class of cases as protargol. In gonorrhœal ophthalmia, however, it is, in my experience, nothing like so efficacious, whereas in acute catarrhal ophthalmia—the "blight" of the London poor—it is a veritable specific. It seldom causes pain or other discomfort. Like protargol, it may discolour the conjunctiva if applied for longer than a few weeks, about a couple of months representing the limit beyond which one cannot safely go.

Argyrol.—This, the latest and unquestionably the best of the organic silver compounds, is also known as "silver vitellin." It does not coagulate albumen, neither is it decomposed by the sodium chloride of the tears. It contains a high percentage of silver (30 per cent.); it is not in the least irritating to the eye; and its powers of penetration are very pronounced. It is extremely soluble in water. It is claimed that argyrol never stains the conjunctiva, no matter in what concentration nor for how long it may be applied. In the light of one patient whose conjunctiva became lightly discoloured after the prolonged use of a 15 per cent. solution, this statement must be modified. It would be more correct to say that argyrol has compared with the other products of silver, very little tendency to stain the conjunctiva. This simple fact at once gives argyrol a superiority over the other salts of silver, organic or inorganic, although it is very difficult to explain, more especially when one recalls the ease with which argyrol is able to penetrate animal tissues. The fact nevertheless remains, and forms an additional argument, if one be needed, for the employment of argyrol upon a wider scale.

My observations with argyrol now extend over a period of about two years, and embrace the treatment of practically every superficial inflammation of the eye. For example, I have used it in all kinds of conjunctivitis, in blepharitis, in phlyctenular conditions of the cornea and conjunctiva, and in diseases of the lacrymal passages. Despite its high ratio of silver-content, I have never yet known it occasion the least pain, irritation, or reaction. No caustic or escharotic action ever follows its use. My experiments have been made with a 15 per cent. solution, except in cases of gonorrhœal ophthalmia, where a saturated solution had been applied. The weaker liquid has been dropped into the eyes by the patient himself two to eight times a day, according to the kind and severity of the inflammation. The stronger liquid has been painted over the exposed conjunctiva, first carefully freed from discharge, once or twice in the twenty-four hours. Almost the first thing that struck me about argyrol was the fact that many patients volunteered the statement that even after the initial application, relief to symptoms was obtained. Indeed, it appeared to act as a direct sedative to the inflamed mucous membrane.

Argyrol, like all silver preparations, tends to stain linen on which it may be dropped, but a solution of potassium iodide speedily removes the marks thus produced.

There are two special ways of applying the new medicament to the eye that deserve to be mentioned definitely, so useful have I found them, especially in hospital work, where cases of the kind abound. There are few more disheartening tasks than to attempt to cure a case of severe ulcerative blepharitis. It is comparatively a simple matter to obtain improvement, but actual cure is quite another thing. In this disease, as in many others, argyrol has rendered me yeoman service. My plan is to rub the inflamed lids vigorously with a pledget of wool soaked in a 25 per cent. solution of argyrol, and to repeat the process, at first daily, and later at longer intervals. This, combined in the more severe cases with occasional cauterisation of the little ulcers lying at the roots of the lashes with the acidum carbolicum liquefactum of the British Pharmacopœia, is the best treatment that I have ever adopted in rebellious cases. The second condition with which everybody must be more or less familiar is eczematous (phlyctenular) conjunctivitis or keratitis complicated with marked photophobia blepharospasm and watering of the eyes. Such patients under ordinary methods are often "blind" for months together. An ointment containing 10 grains of argyrol to the ounce of vaseline is simply invaluable in this condition, and when the photophobia is very intense, two to four grains of alkaloidal atropine and a similar amount of alkaloidal cocaine may with advantage be added to the prescription. The ointment, whether simple or combined, should be applied two or three times a day. There are few cases even of the most intense and rebellious photophobia that will not yield to this treatment, especially if at the same time the patient's forehead be painted daily with liniment of iodine until the skin becomes sore and slightly cracked. I need say nothing of constitutional remedies, which are called for pratically in every case of phlyctenular disease.

General Conclusions as to the Use of Silver.—Nitrate of silver owing to its irritating, nay, dangerous qualities, and its small powers of penetration, should be used little, if at all, in the treatment of the superficial inflammations of the eye. In severe ophthalmia, such as that associated with the gonococcus, it should be replaced by protargol, 50 per cent., or argyrol, 50 per cent., while in the slighter forms of acute conjunctivitis, such as those caused by the Koch-Week's bacillus or the pneumococcus, argyrol, 15 per cent., may well be used in its place. Weak solutions (5 per cent.) of either protargol, largin, or argyrol may be employed in the secretory purulent affections of the lacrymal sac and passages, and may in those cases with advantage be syringed through the diseased parts, after the duct has been surgically treated, so as to restore its patency. The staining propensities of largin and especially of protargol make me give the preference to argyrol as an agent for general employment. Its recent introduction into practical ophthalmology marks a forward step.

A few other antiseptics should be mentioned, *viz.*' chinosol, chlorectone, sublamin, sodium hyposulphite, cuprocitrol, collargol, cuprol, mercurol, formalin, and trikresol. Time, however, precludes me from attempting to describe their individual powers, properties, and uses in ophthalmic work.

Mr. Charles Wray (*Lancet*, April 29th, 1905) has recently described a most effectual way of employing argyrol in that obstinate condition, follicular conjunctivitis. He first empties the follicles by means of pressure between the two thumb nails, and touches the parts with argyrol, 20 per cent. The argyrol is fixed in the tissues by applying a little adrenaline, 1 : 1,000.

(*To be continued.*)

PREVENTABLE DISEASE IN THE NAVY. (*a*)

By GERALD SICHEL, F..R.C.S., late Surgeon R.N.

Venereal Disease.—First and foremost among preventable diseases I would put venereal disease, and at once ask myself, Is this disease preventable after all? It is one which has been the bugbear of the naval surgeon for all time, and up to the present we seem to be nearly as far from solving the difficulty as ever. I say nearly as far advisedly, for without a doubt the wider use of iodide of potassium, owing to its lessened price, has done much to prevent the more lamentable results of tertiary syphilis, and it is seldom given to the present generation to see the extensive cases of

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(*a*) Paper read at the Royal Institute of Public Health, London Congress July 1905.

rupia or gummata which were so common, especially among seamen, some thirty years ago.

But as regards the incidence of the disease, neither the abolition of fines among seamen, nor the Contagious Diseases Act, nor higher education among the lower classes, can be said to have done any apparent good. The difficulties with which this question bristles, and deference to Mrs. Grundy, leads venereal disease to be less discussed than it should be by far, to the detriment of both the service and the taxpayer. The army lately appointed a special committee and a special commissioner (an army medical officer) to consider the matter, and no expense was spared to make their report a most valuable one. I should like to see the Admiralty wake up to their responsibility and do likewise.

Scabies.—Scabies is a preventable disease, and although I am not utopian enough to imagine that it will be entirely prevented, I still think that some routine service treatment should be prescribed throughout the navy. This also is a matter for an expert committee to deal with.

The way in which at present " bad-hats " and other loafers conveniently get into hospitals, and thus avoid unpleasant duties, or, perhaps, being drafted abroad, under the cloak of venereal disease or scabies, is appalling. I myself have been " done " time after time, and strongly feel that not special wards, as is at present the case, but special hospitals, and special regulations, should be kept for these cases. To the shore-going practitioner there must seem a wide difference between the two diseases, but the naval surgeon, while recognising that there are many exceptions, quickly learns to appreciate the fact that in the home hospitals at least the majority of the patients in the venereal and itch wards are deserving of but scant sympathy.

Mental Disease.—The amount of mental disease occurring in the navy, although not great, is sufficient to call for attention. Dr. Johnson said that a seagoing life was an unnatural one, and this saying of his has been quoted *ad nauseam*. It applied in his day of masts and yards and uncertainty, but hardly to-day with steam. The fault rather is that although wooden sailing-ships have given place to steel steamships, the regulations for the control of the crews remain much the same. But this is being altered, and all, I think, for the best.

Perhaps the majority of mental cases may be classified under the heading of " General Paralysis of the Insane," and in the navy, as out of it, the causes of this disease may be put down as civilisation plus syphilisation. In other cases alcohol and excessive smoking—particularly cigarette smoking—play a part. Either the over indulgence in these is part of the self control breakdown, or else it is a causative factor; probably the former.

Although it is no part of this paper to deal with remedies, I shall venture to suggest one here. The building-up of the mental side of the organism is far more subtle than that of the physical, and the effects of education, good or bad, are far more lasting.

The critical age of puberty and the next few years require especial advice and watchfulness on the part of those responsible for the welfare of the rising generation. A naval training does not provide for this, and it is difficult to see how it can do so without becoming grandmotherly; my remedy would simply be to impress this point on those in charge of boys and the gun-room. It does not seem much of a remedy, I admit, but if those responsible could be reminded of their responsibility by something tangible, such as a paragraph in the King's Regulations, I feel sure the service would be the gainer.

Phthisis.—The overcrowding and lack of ventilation in ships prove a veritable hotbed for tubercle, once introduced.

The cure here lies in prevention; this means early diagnosis, which is probably best attained by microscopical examination of the sputum. But I am afraid that the navy cannot look to the State for any helpful ideas here. A nation which recognises that tubercle is a rankly infectious disease, and which approves of the building and upkeep of expensive sanatoria—or, worse still, leaves these establishments to private enterprise—and yet omits to make such a disease compulsorily notifiable, is obviously without any medical policy whatever; and such, indeed, is the case. The medical profession as a profession will not assert itself, and the State somewhat naturally, although to its own great detriment, will not recognise the medical profession.

Carious Teeth.—The importance of this fruitful source of disease is well recognised by the Admiralty, who have recently appointed official dental specialists at Chatham, Portsmouth, and Plymouth. It is to be hoped that these appointments will be followed by similar ones in Malta and other naval bases abroad, because it is in tropical and subtropical climates where the teeth seem to " go " easiest, and where defective dentition and digestion are most fraught with dire results. Although these specialists are being appointed, we must not forget the excellent work done in the past by naval surgeons themselves in this branch.

Mediterranean Fever.—This disease, I suspect, will be found ere long to be preventable, the connection with bad sanitary arrangements is so obvious. The geographical limits of the disease reach far beyond the Mediterranean, and the amount of invaliding which it leads to in the navy is appalling. There was an interesting and most instructive paper published recently in the *British Medical Journal* by Surgeons Ross and Levick, and Dr. Eyre of Guy's Hospital is doing sound work, in the hope of producing a preventive serum. As far as Malta—the hotbed of the disease—is concerned, I would like to see a thorough investigation of the underground water-tanks at Bighi Hospital instituted. In my time it was proverbial that a man who came into the hospital with a broken leg invariably went out with Mediterranean fever.

In War-Time.—With the assistance of properly constructed hospital-ships, we shall without doubt be able to add largely to the list of preventable diseases. The Admiralty have acknowledged their recognition of the want of such ships in accepting as a gift from the American nation the hospital-ship " Maine "—I believe I am correct in saying this. This is a notable example of the half-hearted methods of the Admiralty when medical needs are to be considered. If hospital-ships are unnecessary, then the taxpayer should not be burdened with the upkeep of one; on the other hand, if they are necessary, then the British Navy should not be obliged to fall back on the charity of another nation in order to obtain one. One! We want half a dozen, and shall want more in war-time.

Whenever in any particular ship the question of a naval action is discussed, the point arises, " What shall we do with our wounded ? " although, by-the-by, the question asked as a routine one by the inspecting Admiral is put not to the doctor, but to the Captain. We have had a great opportunity of adding to our knowledge of this particular matter in the recent heavy naval engagements of the Japano-Russian War, and it is satisfactory to know that the Admiralty have appointed a highly-distinguished Fleet-Surgeon especially to investigate the Japanese methods. This appointment, we may hope, is a token that their lordships are beginning to awaken to their responsibilities in matters medical, and one which redounds exceedingly to the credit of the Medical Director-General.

Under the auspices of the National Committee for the establishment of sanatoria a site has been secured at Benenden in Kent, where it is intended to erect an institution for 200 men and women, at a cost of £50,000. An inexpensive class of building is to be erected. The Post Office employés are to benefit by having secured to them a certain number of beds, towards the maintenance of which they will contribute.

British Medical Association.

Seventy-Third Annual Meeting, July 24th to 28th.

[From our special correspondent.]

Third Article.

Among the most useful features of the annual meeting of the British Medical Association, the Pathological Museum and the Exhibition must be accorded foremost places. The former is essentially scientific, while the latter is mainly utilitarian. There is need for both. Many have unwisely discouraged and discountenanced the association of commercial enterprise and trade benefit with the chief yearly gathering of medical practitioners. It is clear, however, that the physician and surgeon can be of but limited service unless assisted by the pharmacist and chemist, the instrument maker and manufacturer of sanitary and hygienic appliances. It is, therefore, of the greatest importance that the annual exhibition of drugs and instruments and all material employed in the practice of the healing art or connected with the prevention of disease, should be kept in close alliance with all that makes for scientific advance and ethical progress.

We are glad to be able to record that these two important departments have this year attained to a high level of success, and have admirably demonstrated their right to merit loyal support.

The Pathological Museum.

The annual collection of pathological preparatians was well arranged in one of the large rooms of the technical schools. The excellent catalogue gave reference to 867 exhibits. The Committee responsible for the Museum have admirably fulfilled their task. They arranged that the collection was a demonstration and exemplification of the work of the Sections. Readers of papers and those taking part in the discussions had been invited to place their specimens and illustrations in charge of the Museum authorities. Exhibits had also been gathered together illustrating recent research work. Thus, for example, M. Roux, of the Pasteur Institute, lent specimens of the organism which is alleged to be the cause of syphilis. Another feature of the Museum was the grouping of series of exhibits giving illustrations of pathological lesions affecting the same organ under different conditions; thus an excellent series of preparations illustrated the effect of disease on the bone-marrow. Comparative pathology also found a place. A series of photographs illustrating ovarian and uterine lesions in rabbits attracted attention. It is greatly to be desired that the annual Museum should be thoroughly representative of the best work of the past year and should satisfactorily illustrate the various subjects discussed in the various sections, and this year's well-selected and judiciously arranged collection has gone far towards realising such.

Undoubtedly one of the chief features of the Museum was the admirable collection of Gynæcological preparations. Specimens had been brought from many of the London and provincial museums and many private collections, and illustrated almost all forms of ovarian and uterine disease. There were no fewer than 414 separate exhibits in this Gynæcological Section. Among so many preparations of exceptional interest it is difficult to individualise, but special praise is due to Mr. C. J. Bond's excellent series of photographs illustrating the pathology of the female genital organs.

In the Section of Pathology, Dr. F. W. Mott showed coloured drawings and photographs illustrating trypanosomiasis, sleeping sickness, various forms of meningitis, and microscopical specimens illustrating the fibrillary structure of the neurones of the cortex cerebri prepared according to the new Ramon y Cajal method.

Captain Leonard Rogers had coloured plates portraying the development of flagellated organisms from Leishmann bodies. Mr. Richard Muir exhibited a remarkably fine collection of photo-micrographic transparencies. A very instructive exhibit was that of Dr. W. Sampson Handley, illustrating permeation as the principal factor in dissemination of mammary cancer.

Dr. K. Grossman displayed a number of beautifully prepared photographs.

Dr. Carnegie Dickson's exhibit of specimens and microscopic photographs of bone-marrow under various pathological conditions was of exceptional interest and value.

Mr. C. C. Hurst exhibited two specimens selected to illustrate Mendel's law of heredity. These preparations were recently shown at the Royal Society's Conversazione and now, as then, attracted much attention.

Professor Sims Woodhead and Dr. G. S. Haynes sent an interesting collection of preparations.

Dr. R. H. Bolam displayed a valuable series illustrating aneurism of the left ventricle. Mr. A. Stanley Green had a large collection of excellent radiographs.

Many interesting photographs of dermatological interest were exhibited by Mr. A. T. Bremner, Dr. H. B. Brimacombe, Dr. F. H. Jacob, Dr. H. J. Neilson, Dr. P. Boobbyer, Dr. Allen Warner, and others.

In the Section of Surgery, Mr. Noble Smith had a good collection of radiographs. Mr. W. Rutherford Morrison showed a very interesting series of specimens illustrating the pathology of the gall-bladder prepared and mounted by Mr. J. Grey Turner.

Mr. C. J. Bond exhibited a number of specimens taken from the collection of the Leicester Infirmary.

Mr. P. J. Freyer showed a large number of specimens the result of his more recent prostatectomies. Mr. C. Thurston Holland had a most instructive series of radiographs illustrating foreign bodies, calculi, diseases of bone, fractures, and deformities. Mr. James Berry exhibited a series of eighteen thyroids removed by operation.

In the Section of Psychology were many drawings and photographs lent by Dr. James Shaw illustrating forms of mental derangement. Mr. W. A. Potts showed photographs of defective children.

In the Section of Laryngology and Otology, Mr. Albert A. Gray had a collection of preparations of the membranous labyrinth in man and animals. Photographs and drawings were also shown by Dr. H. Smurthwaite, Dr. Jobson Horne, and Mr. C. J. Bond.

In the Section of Army and Navy, Fleet-Surgeon C. Marsh Bradnell had a very interesting exhibit illustrating the penetrative power of Remington, Mauser, Lee-Metford, and other forms of bullets.

In the Section of Tropical Medicine, coloured drawings and photographs were shown by Dr. F. N. Sandwith, Dr. Radcliffe-Crocker, and Dr. J. M. H. McLeoad.

Mr. Jonathan Hutchinson, who has for long been a strenuous supporter of museums and has laboured incessantly as a collector of specimens illustrative of clinical medicine, very fittingly provided a most valuable series of drawings.

The Pathological Committee under the Chairmanship of Mr. Charles J. Bond have merited much praise for having so admirably collected and collated much material having a very distinct bearing on present day research.

The Catalogue of 75 pages forms a workmanlike guide and permanent record of considerable value. We could have wished that it had been possible to add an index of exhibitors and exhibits.

King Edward VII.'s Hospital for Officers, 9, Grosvenor Gardens, will be closed from to-morrow (10th inst.) for one month.

Yellow Fever in New Orleans.

Since the outbreak of yellow fever there have been 452 cases in New Orleans. It has been decided to request the Federal authorities to take charge of the arrangements for the stamping out of the epidemic.

Plague in India.

During the week ending July 1st, the deaths from Plague in India numbered 2,201. Of this number 1,253 occurred in the Punjab, 319 in the Bombay Presidency, 132 in the United Provinces (North West Provinces and Oudh) and 167 in Burma.

The Quatercentenary of the Royal College of Surgeons, Edinburgh.

[FROM OUR OWN CORRESPONDENT.]

Fellowships conferred *honoris causa* (list concluded from our last issue).

Professor Bier, Bonn.—August Bier, was formerly assistant to Von. Esmarch of Kiel, and thereafter Professor at Greifswald. He is well known by his contributions to the physiology and pathology of the blood and has shown the value of hyperæmia as a method of treating tubercle, acute inflammations, and other morbid conditions. He has written on the transfusion of animal blood, and on the treating of fractures by the injection of blood; he originated the method of spinal anæsthesia.

Professor Vincenz Czerny.—Geheimrath Dr. Vincenz Czerny, Professor of Surgery at Heidelberg, is the oldest representative of the famous Bellroth School. In 1871 he was appointed director of the surgical clinique at Freiberg, and six years later was called to the Chair of Surgery at Heidelberg. He is a pioneer in the department of gastro-intestinal surgery, and his writings on the extirpation of the larynx and œsophagus and on vaginal hysterectomy have become classics. I ask you to confer on him the Fellowship *in absentiâ.*

Professor Franz Konig.—The present Professor of Surgery at Jena, Dr. Konig, enjoys a world-wide reputation as a surgeon and teacher. His masterly treatise on surgery has gone through eight editions since its publication in 1876. From 1873 to 1895 he was Professor of Surgery at Göttingen and there obtained his unrivalled experience in tuberculous bone and joint disease. In 1895 he succeeded Bardeleben at the Charité Hospital, Berlin, whence he went to Jena. He has the high distinction of being an honorary member of the German Surgical Society, and I ask you to confer on him the honorary Fellowship *in absentiâ.*

Professor v. Mikulicz-Raducki.—Among the distinguished German surgeons whom the College had selected as recipients of its honorary Fellowship was Professor Johannes v. Mikulicz-Raducki, of Breslau. He had arranged to come and be our guest here, but within the last few days we have learned of his sudden and unexpected death. I ask you to be allowed to forward to his relatives the diploma he would have received, along with our sympathy for them in their loss.

Professor Dinante, Italy.—The Director of the Surgical Clinique in the University of Rome is one of the most prominent Italian surgeons of to-day. He has made his name famous by many contributions to the surgery of the cerebral nervous system, of which branch of surgery he is a pioneer and acknowledged authority.

Baron Saneyoshi.—It is especially pleasant in our cordial relations with Japan to have the opportunity of offering to Baron Saneyoshi the highest honours of our College. A brilliant surgeon, he has written a standard work on military surgery, and as in the troubled and anxious state of his country it is impossible for him to be present I ask you to confer the Fellowship *in absentiâ.*

Professor Subbotin.—Among the representatives of Russian surgery Maxim Subbotin holds a very high place as Professor of Surgical Pathology and Therapy in the Military Medical College of St. Petersburg. As he is unable to be present, I ask that you confer the Fellowship on him *in absentiâ.*

Professor Lennander, Sweden.—The Professor of Surgery in the University of Upsala has written valuable papers on the surgery of the kidneys, biliary passages, appendicitis, and peritonitis, while his work on the sensory innervation of the abdominal cavity enjoys a world-wide reputation.

Professor Kronlein.—The Director of the Surgical Clinique at Zurich and President of the German Society of Surgeons, after serving in the Franco-German war, became assistant at Zurich. Thence in 1874 he went to assist Langenbeck in Berlin, and was recalled to the Chair he now occupies in 1881. He has contributed largely to our knowledge of cerebral topography, and of the treatment of wounds in general. I ask you to confer on him the honorary Fellowship *in absentiâ.*

Professor Halstead.—The Johns Hopkins University, founded so recently as 1876, has been the home of many distinguished surgeons, and among those who have added lustre to the School no one stands higher than William Stewart Halstead, who is already an honorary Fellow of the Royal College of Surgeons of England, and to whom no higher compliment can be paid than in saying that many of those trained under him have already attained universal celebrity.

Professor Keen.—It would be difficult to find a surgeon more representative of the great American Continent than William Williams Keen, Professor of Surgery in the Jeffreson Medical College, who has been recognised by nearly all the medical scientific societies throughout the world as a distinguished teacher and operator, a writer on cranial surgery, and an authority on diseases of the larynx.

Dr. Howard Kelly.—Among those who have perfected gynæcological technique, Dr. Kelly's place is pre-eminent; he has been a keen, patient, and successful operator and a recognised pioneer in every department of abdominal surgery. He is second to none in his marvellous dexterity in dealing with difficult cases, and has enriched the literature of his subject by works which will remain a permanent monument of his industry and skill.

Dr. Mayo.—Though a comparatively young man, he has already obtained a most extensive and well-earned reputation in abdominal surgery. Among the distinguished American surgeons whom this College delights to honour no one is more prominent in his own country than William T. Mayo, Surgeon to St. Mary's Hospital, Rochester, Minnesota.

Professor McBurney, New York.—There is scarcely any learned medical society on the American Continent of which Mr. Charles McBurney is not a member. He has occupied almost every position of eminence in Harvard University and in New York. and his numerous contributions to surgery, notably to abdominal surgery, have advanced our knowledge in no small degree. I regret that I am obliged to ask you to confer on him the honorary Fellowship *in absentiâ.*

Professor Warren.—In selecting a representative of Harvard, no more distinguished surgeon than J. Collins Warren, M.D., could have been chosen. He is the author of many valuable papers on surgical pathology and therapeutics, and is joint editor of an international text-book of surgery. It is interesting to notice that his grandfather was the first to employ ether as a general anæsthetic.

This concluded the list of foreign representative surgeons on whom the honorary Fellowship was bestowed, and next in order came the British and Colonial recipients of the honour. As these were naturally better known to the audience, the promoter's remarks about each were comparatively brief. The honorary Fellows Elect were as follows:—

Lieutenant-Colonel Gerard Bomford M.D., C.I.E., Director General of the Indian Medical Service.

Irving Heward Cameron, M.B. F.R.C.S. Eng. (Hon.) Professor of Surgery and Clinical Surgery, University of Toronto.

Arthur Chance, President of the Royal College of Surgeons of Ireland. In presenting him Sir Halliday Croom said: In selecting Mr. Arthur Chance for the honorary Fellowship, the College desires to acknowledge the cordial relations with the sister College in Ireland, and to offer its congratulations to him who occupies the distinguished position of being its President. Late Surgeon-Ordinary to the Lord Lieutenant of Ireland, he is a member of the Council of the Royal Academy of Medicine of Ireland, and holds many hospital appointments in Dublin. He is well known as the author of many valuable contributions to surgical subjects, mainly in the department of abdominal surgery.

Henry Edward Clarke, C.M.G., President of the Faculty of Physicians and Surgeons of Glasgow, Professor of Surgery St. Mungo's College, and Surgeon to the Glasgow Royal Infirmary. The promoter alluded specially to his services to the nation rendered during the South African War.

Herbert Mackay Ellis,Director-General of the Naval Medical Department.

Sir Thomas Naghten Fitzgerald, C.B., M.D., Honorary Surgeon, Melbourne Hospital, President of the Medical Society of Victoria (*in absentia.*)

Alfred Henry Keogh, C.B., M.D., Surgeon-General Royal Army Medical Corps, Director General Army Medical Department.

Lord Lister, F.R.S., D.C.L., LL.D., Serjeant-Surgeon to his Majesty the King, of whom, said the promoter, it would in this College be an impertinence on his part to do more than mention the name, intimately as he had been associated with Edinburgh. Renowned as a scientific investigator, and hailed as the prince of English physiologists, his services to humanity rendered his name immortal. On account of ill-health Baron Lister was unable to receive the Fellowship in person, and it was conferred *in absentia.*

Alexander McCormick, M.D., Lecturer on Surgery in the University of Sydney.

John Playfair, M.D., President of the Royal College of Physicians of Edinburgh.

John Tweedy, M.D., President of the Royal College of Surgeons, England, who was presented by Sir Halliday Croom as one of the most distinguished ophthalmic surgeons of the day. Besides holding many important positions in the ophthalmological world he has contributed largely to medical history, education, and politics, and has on two occasions occupied the Chair of the Royal College of Surgeons of England.

Frank J. Shepperd, M.D., Professor of Anatomy in McGill College, Montreal, representing the premier colony of the King's dominions beyond the seas.

The ceremony of conferring the honorary Fellowships over, the gentlemen who had received the honour mounted the platform in turn, and briefly acknowledged the courtesy of the College of Surgeons. It was noticeable that most of the replies were couched in English. Professors Eiselsberg, Saxtorph, Lucas Championnière, Bur, and Lennander all delivered neat and appropriate speeches in the mother tongue of their audience. M. Lucas Championnière recalled the days when he had studied in Edinburgh under Lister, and said that the honour reminded him of the old friendship between Scotland and France. He offered thanks thrice—thanks from his College, thanks from himself, and thanks from France. Professor Keen in a humorous reply, said he that day disputed the Virgilian maxim, and welcomed, not feared, the gift-bearings of the Scots. Though through his father he was a countryman of Professor Lennander, through his mother he was English, through his grandmother Welsh, and he was now somewhat of a Scot. If he went to Ireland and obtained a little of the brogue, he would be "Votus, teres, atque rotundus."

Congratulatory Addresses.

The final part of the commemoration proceedings consisted in the presentation to the College of congratulatory addresses from various bodies. Owing to the protracted nature of the ceremony, only a few of these were read, the majority being simply handed to the President, who acknowledged them in a word of thanks. The following addresses were presented:—The University of St. Andrews.—By the Dean of the Faculty of Medicine, Professor Reid, and the Principal of University College, Dundee, Professor Yule Mackay. The University of Glasgow.—By the Dean of the Faculty of Medicine, Professor Murdoch Cameron. The University of Aberdeen. By the Dean of the Faculty of Medicine, Professor R. W. Reid. The University of Edinburgh.—By the Principal, Sir William Turner, K.C.B. The Royal College of Surgeons of England.—By the President, Mr. John Tweedy. The Royal College of Surgeons of Ireland.—By the President, Mr. Arthur Chance. The Royal College of Physicians of Edinburgh.—By the President, Dr. Playfair, and the Treasurer, Dr. P. A. Young. The Faculty of Physicians and Surgeons of Glasgow, By the President, Professor H. E. Clark. The Royal Society of Edinburgh.—By the Senior Vice-President, Professor Geikie. The Edinburgh Medico-Chirurgical Society.—By the President, Professor Chiene, C.B. The Edinburgh Obstetrical Scoiety.—By the President, Dr. N. T. Brewis. The Royal Medical Society.—By the President, Dr. R. J. Johnston. The Merchant Company of Edinburgh.—By the Master, Mr. John Harrison. The Managers of the Royal Infirmary of Edinburgh.—By the Chairman, the Lord Provost.

The whole commemoration ceremony was watched by a large and attentive audience, and was characterized by marked enthusiasm and cordiality. The deatils had been carefully arranged beforehand, and the whole proceedings passed without the slightest hitch.

In the evening a reception was held in the Royal Scottish museum. It had been originally intended that the function should take place in the College of Surgeons, but owing to the large number of acceptances it was found that the accommodation there would lead to overcrowding; accordingly a change of venue was decided on, which greatly conduced to the comfort of the guests who numbered over two thousand. Among many distinguished persons present, special mention must be made of M. Cambon, the French Ambassador to the Court of St. James's, who happened to be the guest of the Lord Provost of Edinburgh at the time. The earlier arrivals were received by Professor Chiene, in the absence of Sir Patrick Heron Watson, who, along with his daughter, Mrs. Haig Ferguson, acted as host later on in the evening.

Other Quatercentenary Celebrations.

The second day of the Quatercentenary celebrations was given over to a Garden Party in the afternoon and a Banquet in the evening. The former was held in the grounds of George Heriot's Hospital in Lauriston Place, just opposite the Infirmary. The quadrangle, chapel, and board-room with its portraits were opened to the guests, many of whom, though natives of Edinburgh, had not previously had an opportunity of inspecting the valuable portraits and quaint carvings which are to be seen there. Fortunately, the day continued fine, and the gay frocks and millinery made a brave display. About half-past four o'clock, M. Cambon, the French Ambassador, accompanied by the Lord Provost, appeared on the scene. He was received by the strains of the "Marseillaise," and then made a tour of the hospital, drinking the immortal memory of George Heriot from the ancient loving cup which is reputed to have belonged to the worthy "jungling Geordie" of romance.

After the Banquet, the Loyal Toasts were proposed by the President, and the Corporation of Edinburgh by the Vice-President, Sir Halliday Croom. The President then proposed "The Honorary Fellows of the College" in a short speech, and coupled with the toast the names of Professor Fresherr v. Eiselsberg and Dr. Halsted. Professor v. Eiselsberg said that from his master, Billroth, he had learned how much English medical men had helped their science. Amongst the best of them were Edinburgh men. He would not recall them all—Benjamin Bell, Monro, Hunter, Fergusson, and Lyall. But he asked leave to name two—Simpson and Lister, one of whom eliminated pain, the other danger, from operations; the two were the greatest benefactors of the nineteenth century.

Dr. Halsted, in responding, said that during the functions Herbert Spencer's remark that the conferring of honorary degrees was an ill-advised institution, had recurred to his memory, but he was sure that none of the Fellows present would endorse the sentiment

The hospitality they had received had really been a revelation to Americans. It had taught them in the first place what good manners were. Americans had their ideas of good manners and of what they consisted, but such attention as they had received here was something they knew not of in America. He would not review, as had been so ably done by his predecessor, the names of the great Scotsmen of whom they had heard so much during the past few days, but he should like to ask if it would not be out of order, that they should send a wire to Lister to remind him that they were thinking of him that night, for if it had not been for him, this anniversary would have been of a different character, and, indeed, it would have been impossible to have found men who had contributed enough to the science of surgery on whom they could have conferred the degree of honorary Fellows.

Sir William Turner thanked the guests, in the name of the President, for their presence at the Festival. It would be acknowledged that they had before them a goodly assemblage—one that they might be proud of, met to celebrate the great festival of their 400th anniversary. He then referred to the guilds or corporations which they had in England, Scotland, and Ireland, because these medical corporations were characteristic of the British Isles, and did not exist on the Continent. They were formed in the sixteenth and seventeenth centuries, when professional men came to the conclusion that it would be a wise thing to join themselves together and form guilds. The corporations were corporations which owed their origin not to the State but to the enterprise of members of their own profession. From the efforts of those combines there emerged a system of medical education which gradually perfected itself, a method of testing those systems of education by examination, and, what was more important, a sentiment of professional honour—a code of conduct which should regulate the action of medical men to one another and to the public. Many who were assembled in that hall had come because they recognised the value of that corporate combination. But this motive was not one which could affect their Continental brethren, who had come to meet them in the City because they remembered that all were members of a common profession—of a great profession—and of a profession whose function it was to probe into the causes of disease, to try to get rid of disease, and to put the practice of medicine on a sure foundation. England and France were neighbours in geographical proximity, in thought, and in feeling. They represented the two great nations of Western Europe with whom freedom of speech and freedom of thought were the necessities of life. They welcomed M. Cambon to their board because he was the bearer of friendly feelings toward them. The two nations had noble examples in King Edward VII. and M. Loubet, who had done their best to inculcate friendly feelings between them.

M. Cambon, who replied in French, thanked Sir William Turner with all his heart for the kindly references he had made to his country and himself. A *rapport* between France and Great Britain favoured the ideas of liberty and development throughout the world, and so long as he had life he would try to work for a good understanding between the two nations; of such a cause they had no more ardent supporters than King Edward VII. and President Loubet. In the name of the guests he thanked them for their generous hospitality.

Sir John Ure Primrose, Lord Provost of Glasgow, proposed the toast of the Royal College of Surgeons, Edinburgh, in an eloquent speech, in which he quoted as a picture of a good physician the lines on the tomb of Dr. Peter Low, Founder of the Glasgow Faculty, in the Glasgow Cathedral:—" Stay, Passenger, and view this stone, For under it lys such an one Who cur'd many while he liv'd; So gracious he no man grieved; Yea, when his Physic's force oft failed, His pleasant purpose then prevailed, For of his God he got the Grace, To live with mirth and die in peace. Heaven has his Soul, his corps this Stone, Sigh, passenger, and then begone." After the President had acknowledged the toast in a few words, the evening was concluded, and with it the Quatercenterary Festival, by the company singing the National Anthem, and " Auld Lang Syne."

Although not actually forming a part of the official celebrations the festivities were suitably terminated by the conferring by the University of the honorary degree of Doctor of Laws on the French Ambassador, and nine distinguished representatives of the medical Profession on Saturday, July 22nd.

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, August 5th, 1905.

At the German Society for Surgery, Hr. Czerny Heidelberg, spoke on

Prostatectomy.

He said that the treatment of enlargement of the prostate was formerly carried out by the catheter, but that now prostatectomy had been performed with good results; Bottini's operation did good service in rare cases only; catheterisation always carried with it the danger of infecting the bladder, but life could be prolonged for years by its use. If there was great difficulty with the catheter, the radical operation was indicated, as the operation developed it would be performed at an earlier stage. It was well borne even in advanced age, impotence and incontinence might easily be set up, but these drawbacks were frequently better than the disagreeableness of catheterization. The best results of prostatectomy had been obtained in recent cases, but these could be almost always permanently cured by the catheter *à demeure*. The best indication for the radical operation was old cases of hypertrophy of the prostate along with a healthy condition of the bladder and kidneys.

Which method of operation, the perineal or the transvesical, was not yet sufficiently decided for a pronouncement. By the first a better drainage was assured; the latter was less liable to damage potency. As an operation the perineal was to be preferred. He had operated fifteen times. Two of the cases died, one from sepsis, one on the evening of the operation (cause of death unknown as an autopsy was not permitted). The technique of the operation was still incomplete.

Hr. Kümmell followed on the same subject. He said the radical operation had obtained too little consideration in Germany. He had operated in 114 cases by various methods. Bottini's operation had been performed fifty-one times, but it was not radical, neither was it by any means free from danger as the number of fatal cases showed. With castration, which he had performed twenty-six times, he had obtained really good results, but with two deaths. He had performed both the high and the perineal operation as radical measures in cases in which retention of urine had existed for lengthened periods. The second operation had been performed in cases in which the hypertrophy lay more towards the perinæum, the first when it grew upwards into the bladder. The technique was simpler in the high operation; the prostate could often be twisted off by simple rotation after cutting through the capsule. In the perineal operation the urethra had always to be opened. The radical operation should not be performed when there was disease of the kidneys. Advanced age was not a contra-indication; only when the general condition was disturbed; here Bottini's operation was indicated.

Hr. Lexer, Berlin, showed a large carcinoma of the prostate, the neck of the bladder and the adjoining part of the urethra. It was extirpated after making a flap of the abdominal wall, resection of the symphysis, and longitudinal incision into the bladder. Unfortunately metastasis had formed at Poupart's ligament.

Hr. James Israel had had good results with both operations, the suprapubic had the advantage as regarded easiness of performance. But he would raise one technical point: In infection of the bladder closure of the wound and the placing in of a drain were not sufficient as a depression that retained pus existed below the catheter along with retention of urine. In such cases median prostatectomy was to be preferred when a drain could be inserted. Otherwise both operations were equally good; it was not necessary to keep the patient long in bed.

Hr. Nicolich, Trieste, had performed prostatectomy in thirty-one cases and among them twelve perineal operations with one death. They were all chronic cases with bad retention. The oldest patient was æt. 83, and the result in his case was good.

Hr. Freudenberg, Berlin, would not reject Bottini's operation; it was suitable for special cases. One thing in its favour was that patients submitted to it more readily, potency was not endangered, permanent incontinence after it was rare, and no rectal fistula followed. It was much less dangerous than the others and was quite sufficient when only one lobe of the prostate was diseased.

Hr. Küster, Marburg, had reported six cases of partial prostatectomy in 1889 and the function in all of them was good. In two cases there was injury to the urethra with transient fistula. This operation he had, however, now given up, although it was far less dangerous than complete prostatectomy.

Hr. Riedel, Jena, had for a long time endeavoured to make the partial operation suffice as loss of power over the bladder might follow the total operation. He went from the perinæum and shelled out the prostate with a sharp spoon, taking care not to injure the urethra. He had been quite satisfied with his operation. He had only lost one case from lymphangitis following retention of secretion.

Hr. Hock, Prague, had done partial prostatectomy principally with a view of not injuring sexual function. The result was bad; improvement took place in eight cases, but the patients had had to turn to the catheter again and they had lost their sexual power. The procedure was indicated in recent cases. Bottini's operation was certainly a justifiable one. In a case of carcinoma of the prostate with free bleeding resection of the vasa deferens gave a good result.

Hr. Frank, Berlin, thought suprapubic prostatectomy was the best.

Hr. Kümmell said that he sutured the bladder in the high operation in order to get patients up earlier. After perineal prostatectomy also he allowed them to get up after a few days so that they could breathe better. Partial ectomy would be rarely called for, as it was ouly rarely that the middle lobe was not implicated.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 29th, 1905.

Morbus Basedowii and Röntgen Rays.

AT the Gesellschaft der Aertze, Stegmann exhibited a few cases of morbus Basedowii, which he had treated with the Röntgen rays according to Görl's method of Würzburg. He told the members he had now applied the Röntgen rays to the thyroid gland in thirteen of these cases with excellent result. Others with recent struma parenchymatosa had the breathing greatly relieved, particularly in elderly females, while the circumference of the neck was reduced, but none of the other phenomena seemed to disappear. He showed the effects on a case that had recurred after an operation for adeno-carcinoma of the thyroid in a female, æt. 32. The tumour, when removed a year previously had all the histological constituents of adenoma and glandular hypertrophy consistent with carcinoma. Besides this, a tumour was located in the supra-clavicular space which gave great pain extending down the right arm. After three weeks' treatment the pain disappeared and the circumference of the neck was reduced 3 centimetres—1·17 inches. In three of the cases one month's treatment dispelled all the symptoms of struma with improvement in the cardiac and pulmonary phenomena, the latter falling from 130 to 80 per minute. The attacks of perspiration became less frequent while the exophthalmus was greatly reduced.

In the discussion that followed, Schiff said that he had been induced by seeing Stegmann's results to try the effects on two cases of struma that had given a good deal of trouble and was now satisfied with the result.

Circumscribed Fatty Degeneration.

Among a number of cases which Fuchs exhibited to the members was one with fatty degeneration of syphilitic origin. This was the case of a married woman, æt. 29, who had acquired syphilis through her husband and had twice aborted. During the last two years she had observed herself suddenly becoming large about the lower part of the body, extending over the pelvis to the thighs. The upper part of the body, arms, and lower limbs became gradually smaller, losing all their fat. This decline of the normal fat she observed first in the left breast, which soon extended to the other side, and finally appeared as emaciated. From this emaciation of the unaffected parts, spontaneity and pain on pressure, he differentiated this from Dercum's disease, and designated it circumscribed fatty degeneration.

Protracted Tabes.

Another of these cases was an old man, æt. 75, who about the age of 16, had been infected with syphilis. Not till 1850 was any serious symptom to be traced of tabes, but lancinating pains, feeling of a girdle around him, with slight inco-ordination which continued slowly increasing till he recently committed suicide. Before he committed the act he appeared a strong, healthy well-nourished and robust man.

Another younger case of a man, æt. 59, who cannot define the period of infection, and who has now had the lancinating pains for thirty years, was amongst the exhibits. He had also another female patient suffering from progressive tabes since 1890, which had taken the place of an expansive dementia paralytica, which had arisen through sepsis, and probably later supported by the formation of pus.

In the discussion, Schiller remarked that circumscript adiposis of the lower half of the body was usually due to some nerve disease, probably in this case of Fuchs' to tabes in the lower part of the spinal column, such as the cauda equina. From the patient's history there does not seem to be a single symptom that would point in this direction.

Nævis Sarcomatous.

Albrecht exhibited a child, æt. 10 months, with a nævus over nates and the right lower extremities, which he found on microscopic examination to have a fibro-sarcomatous consistence, arising also from the deeper sheath of the subcutaneous tissue. Along with this was shown resections of the liver and spleen, taken from a butcher suffering from echinococcus.

Injections of Cholin.

Exner further reported on his experiments with cholin in the decomposition of lecithin, which had also been produced by the Röntgen and radium rays. In his previous cases he proved it by subcutaneous injections under the skin and scrotum. He now injects direct into the peritoneal cavity and into the mesentery if possible, where the typical change is to be found in the lymphatic glands and spleen of the injected animal after being killed. In the normal gland large numbers of lymph follicles are to be found, while in the animal experimented on the lymphoid tissue has been greatly reduced and the follicles lost. In the spleen the same change is observed. This, he considered was analogous to Heinecke's experiments with the Röntgen rays. For some time past Schlacta has held, with considerable reason, that this change is due to the alkali contained in the cholin which may now be established as conclusive. He pointed out to the members that there was no eschar or searing of the mesentery or peritoneum nor could any particular change be observed in the glands themselves.

Operating Theatres.

ST. THOMAS'S HOSPITAL.

OPERATION FOR IRREDUCIBLE HERNIA OF AN UNUSUAL CHARACTER.—Mr. BATTLE operated on a boy, æt. 8, who had been admitted for an irreducible hernia of some months' duration. The scrotum on the right side was enlarged and the swelling gave an impulse on coughing but was irreducible. The inguinal canal was occupied by a continuation of the swelling. It was rather peculiar in shape, its lower part being rounded and somewhat the shape and size of a man's little finger. The diagnosis, Mr. Battle said, appeared to lie between irreducible hernia consisting of omentum, which was thickened by inflammatory change and adherent to the inner wall of the sac, or the presence of some such structure as the cæcum which had become thickened by inflammatory change. It was suggested, he remarked, that this lump was a tuberculous deposit in a portion of omentum which had become adherent, but in the absence of any abdominal signs of tubercle, such as thickenings or the presence of free fluid, in the absence of a history pointing to intestinal disturbance, this was considered improbable. Moreover, although adherent omentum is the most common cause of irreducibility of hernial contents, it is rare, he pointed out, to find omentum occupying a prominent part in the hernia of a child. At the operation it was found that the irreducible part was due to the cæcum and appendix which had slipped down and become adherent to the parts around. The appendix, which was a good deal enlarged, occupied the lowest part of the sac, passing from behind forwards; in it could be felt a good-sized concretion. It was shut off from the peritoneal sac and covered in by many adhesions; these adhesions were in fact so numerous that the peritoneum forming the lining of the protrusion was not larger than the end of a small forefinger. The whole of this was, however, thickly studded with tubercles. Examination through the internal ring showed a similar condition of the peritoneum within the abdomen. The appendix was clamped, the stump ligatured, and the appendix cut away beyond the ligature, the remains being buried in the wall of the cæcum; the latter was returned to the peritoneal cavity, the sac cut off after ligaturing, and the operation for radical cure completed after Bassini's method. Mr. Battle said that tubercle of the hernial sac was an unusual complication, and it was met with in cases where there was usually no reason for suspecting the presence of that disease. Occasionally, however, something might suggest it. For instance, in one case, Mr. Battle remembered, in which it was diagnosed, there had been a tuberculous epididymitis on the same side as the hernia; even in the case he had just operated upon the tubercle he thought had probably been responsible for the extensive binding down of the cæcum and appendix, although it gave no evidence of its presence before the sac was opened. It would be interesting, however, Mr. Battle considered, to note the effect of the operation on the peritoneal tubercle. In one patient he mentioned where a tuberculous sac had been ligatured, the boy returned some weeks later with an abscess of the abdominal wall apparently tuberculous, but he has not developed any signs of abdominal disease.

The patient made a good recovery and will probably remain without further complication.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 9, 1905.

THE PASSING OF THE MEDICAL PRACTITIONER.

THERE can be little doubt that the average general practitioner of the United Kingdom is going through more than usually bad times. He is called upon to face competition from quarters that should be the last to injure men of his profession, namely, the medical charities, who not only shower their benefits on well-to-do persons, but take their money in payment for services rendered both as in- and out-patients. Then there is the ever-increasing competition of unlicensed quacks, who are permitted to carry on their nefarious practices at the cost of the legitimate and state-recognised medical practitioners. The root of the evil is the apathy of medical men themselves where their own interests are concerned. That fact has been recognised ever since there have been reformers and grievances in the world of medicine. The lawyers have taken care to defend their legitimate practice with stringent laws administered by the Incorporated Law Society, a body that is wealthy, powerful and watchful to the last degree of all outside agencies that may be detrimental to members of the legal profession. Contrast that state of affairs with the brazen piracy that is carried on openly and on all hands by electricians, beauty specialists, cancer-curers, bone-setters, rupture specialists, Christian Scientists, and a host of similar charlatans. The general Medical Council looks on complacently, for its business is not to protect medical men against illegal competition—it is simply to regulate qualified medical men and maintain the Register. Composed as it is by a vastly preponderant majority of representatives of privileged corporations, the Council is not likely to be in touch with the thoughts, wishes, and aspirations of the general practitioner. With a reformed constitution and charter, the General Medical Council might become a tower of refuge and of strength to the medical profession comparable with the position of the Incorporated Law Society. The first great step towards a better state of things will be to make the Council a representative body. Nor is it easy to understand how men of candour and high position, such as those who now sit on the Council, can cling to a non-representative principle which is an anachronism and a relic of barbarous class administration unworthy of a learned profession. The only explanation possible is that collectively members of the Council accept a position that individually they would hardly attempt to defend. Until medical men help themselves they are likely to remain in their present disadvantageous position. The outside public know little, and care less, for the medical profession as a whole. That attitude is well illustrated by a "silly season" correspondence going on in the public Press at the present moment. Some inspired journalist advanced the proposition that "the doctor's occupation will shortly be gone." That view is supported by the following tokens:— Increased competition for practice. Progress of specialism. Increased medical knowledge of the public. Tabloid medication. Treatment by unqualified practitioners. Swedish methods of treatment. Shortening of the London season. Increased cost of living. Having thus fairly launched his thunderbolt, the next step was to visit a medical agent, from whom he forthwith obtained the column or so of thin literary copy necessary to his purpose. Needless to say, little if any real light was thrown upon the weirdness of the grim tragedy—for tragedy there is—which had originally fired his journalistic instinct. The medical agent's philosophy may be gauged from the fact that he dismissed the item of unqualified practice by the quibble that a man could not practise unless he were qualified. Would that the vast mass of unchecked piracy thus indicated could be disposed of in that quick and airy way. The want of employment was met by the statement that there was a difficulty in finding men to take *locum tenens* work at four and even five guineas a week. This is the sort of stuff which journalists think good enough to foist upon the public where the medical profession is concerned. The underlying moral is not far to seek. It is the old, old story, that God helps those that help themselves, and that the medical profession must look to itself to escape from the nets that have been spread around on all sides. Let us begin with the reform of the General Medical Council.

LONGEVITY.

PROFESSOR OSLER has had to take up the Regius Professorship of Medicine at Oxford under a cloud —the cloud of a joke. We prefer to attribute the ridiculous seriousness with which his *jeu d'esprit* was taken rather to the exigencies of the trans-Atlantic cable than to any obtuseness in our compatriots, but the fact remains that a great many people in Great Britain know Professor Osler chiefly as a man who thinks people are too old at forty and only worthy of comfortable euthanasia at sixty years of age. There can be no doubt that the distinguished head of the medical school at Oxford will, by the exercise of his characteristic energy, dissipate any misapprehensions that may be entertained as to his own practice in the method of employing his time, and we shall be surprised if from the monastic retreat that he has chosen, Professor Osler does not give forth some of the most mature and brilliant work of his life. But the little joke, even if it missed its point, has set people thinking, and at this time of conferences and annual meetings the subject of longevity has employed the tongues of at least two orators—namely, Sir James Crichton Browne at the Congress of the Royal Institute of Public Health and Dr. Charles Stockton, of Buffalo, at the annual session of the American Medical Association. Both these speakers handled the subject of longevity in the spirit of modern evolutionary philosophy, and both by rather different avenues of approach have arrived at the conclusion that length of years is not only a good thing in itself, but that it is attainable in greater or less degree by human effort. The desirability of living to old age is a question with which medicine as an art does not concern itself, any more than it does with the value that the life of a particular patient may have for the community. A medical man is bound by the canons of his creed to save life, even if it be that of a criminal, and to prolong life, even if it be that of a suicide or hopeless sufferer. So, too, in the larger realm of preventive medicine, the object is to prolong life to the utmost of its natural span. Readers of Cicero's "De Senectute' will probably have long made up their minds that not only has old age its peculiar delights, delights which vary from philosophic contemplation as in the case of Plato to feasting and ostentation as in that of Duilius, but its peculiar utility to mankind, as in the cases of Homer, Hesiod, Pythagoras, and a multitude of others. The dotards—"comicos stultos senes," as they were called by Cœcilius—are for the most part pathological products of misspent or unfortunate adolescence. A hale old age with its varied amusements and quiet pleasures should theoretically be the normal ultimate destiny of a well-laid-out life crowning a good constitution. So that in considering the means whereby longevity may be attained the domain of preventive medicine is sensibly widened to include the whole art of civilised citizenship. There must be assured to the citizen a good constitution to begin with and conditions of environment which give that constitution opportunities to ripen, and protect it from blighting influences. The assurance of a sound constitution was the principal theme of Dr. Stockton's address, and he pointed out that this was a matter of heredity, and therefore that the real start in the search for longevity must come through the application of the laws that govern the science of breeding. It is Lamarkism, pure and simple, to expect that education and hygiene will directly influence the stamina of the race, for such a supposition connotes belief in the transmission of acquired characteristics; the propagation of a sound stock must depend on the conjunction of sound ancestors. And here we are landed in all the difficulties, social and political, that surround the new science of eugenics. At the same time it must be admitted as the fact that if the normal span of life is, for the bulk of mankind, to be stretched from three score years and ten to Sir James Crichton Brown's sanguine estimate of five score, something in the nature of the prevention of weaklings and the encouragement of the robust must take the place of our present hap-hazard love-making. Then will those further conditions on which Sir James insisted be capable of effecting their maximum good; without selection we fear centenarians are more likely to be numbered by the score than by the hundred. The intelligent rearing and feeding of children, the prevention of epidemic diseases, the provision of good houses, and the promotion of physical development will all aid in the future, as they have all aided in the past towards lengthening the duration of life, and these questions are constantly agitating the minds of hygienists. But Sir James Crichton Browne takes a bold step further when he tackles the psychical aspect of his subject, for he lands his followers in controversial political questions such as that of old age pensions. To rid the mind of care and worry will most surely affect the duration of life to a considerable extent by postponing the advent of arterio-sclerosis, the greatest single life-shortening influence, but we confess that such a proposition strikes at the root of modern existence to a degree that makes us tremble. Æquanimitas—we find we have come back to Professor Osler again—can be attained for humanity only by a reversal of all the laws of Nature—a complete subjugation of the cosmic processes—an absolutely perfect civilisation. And then we shall have reached not only centenarianism, but also the Millennium.

Notes on Current Topics.

Undesirable Nursing Home Methods.

IN July last a medical man, Mr. Owen Lankester, wrote to the *British Medical Journal* advocating the drug treatment of chronic inebriety by the hypodermic injection of atropine "or one of its allied alkaloids." In the letter he mentioned the name of Mr. A. W. Jamieson, of 1, Mitre Court, Temple, E.C., presumably a barrister, as a gentleman willing to give further particulars. A circular letter has been sent to us from a correspondent, which we reproduce :—

"25, Cheniston Gardens,
"Kensington, W.
"July 15th, 1905.

"Sir,—The above is the address and telephone No. of the special nursing home for alcoholic cases, referred to in Dr. Owen Lankester's recent letter to the *British Medical Journal*, copy of which I enclose. The course is one of *four weeks*, and I can give you the names of a number of other medical men who are thoroughly satisfied with the results of the treatment. May I call and give you full details?

"I am, sir, yours faithfully,
"A. W. Jamieson."

This letter contained a reprint of Mr. Lankester's original letter to the *British Medical Journal.* The whole proceeding appears to be unworthy of the dignity of the medical profession. This advertisement of a special treatment in connection with a special nursing home seems to us to be skating with a vengeance over the thinnest of ethical ice. What has the *British Medical Journal* to say in the matter? No drug treatment of inebriety has yet been accredited by the medical profession, nor does there seem the least likelihood of anything of the kind occurring, although many claims for so-called specific remedies have been made both inside and outside the profession—usually outside.

A Judge on Professional Etiquette.

MR. JUSTICE WILLS is well known as a man of sound intellectual balance, who is not afraid of speaking out his mind. At Birmingham Assizes, last week, he commented severely on the medical evidence in an action for damages brought against the Birmingham Corporation. A medical witness attributed an abscess of the breast from which the plaintiff suffered as the result of the accident which formed the basis of the lawsuit. The defence, on the other hand, called Dr. Lucas, of the Birmingham General Hospital, who is reported as saying that to attribute the debility from which the plaintiff was then suffering to abscess was absurd. It is difficult to gather the exact truth from a condensed newspaper report, but clearly an abscess of the breast may be the direct or indirect cause of almost any kind of "debility," immediate or remote. Whatever Dr. Lucas said, his attitude called forth the remark from Mr. Justice Wills that it was to be regretted that a man holding his position should speak in the manner he did of another medical gentleman. We go further, and say that the contradictory "expert" medical evidence given in courts of law constitutes a standing reproach and scandal to our profession. The ends of justice, moreover, are not likely to be adequately served until medical points are settled by a consensus, at any rate by a majority, report of a body of independent skilled investigators.

Robbery Under Chloroform.

WE fear that the Italian correspondent of one of our medical contemporaries must have been caught napping when he retailed to the journal a sensational story of a gang of hotel thieves who rob their victims after anæsthetising them, but this paragraph has been eagerly copied. The *modus operandi* of the gang is asserted to be as follows :—A likely subject for the experiment having been selected, the thieves engage a bedroom next to his in the hotel, and with special instruments perforate the wall in the neighbourhood of the victim's head. Through this hole thus made a long, fine cannula is passed, and while their innocent prey slumbers whiffs of chloroform are puffed till he is completely anæsthetised. Then the wicked robber forces the door, takes what valuables he fancies, and decamps in the early morning by a "through express." The story with its lurid detail would make a capital plot for a "serial" writer, and we commend the idea to him if he has not already evolved it from that prolific inner consciousness which daily brings forth to an astonished world things old and new. But for medical men we fear it will not "wash." Apart from the improbabilities involved in many of the details, we have yet to see the sleeper who would go through the first stage of chloroform anæsthetisation without a murmur, and though we believe in allowing a good admixture of air when administering chloroform, we hardly think the proportion of chloroform conveyed by a "long, fine cannula" would be sufficient for the purpose. The story reminds us of the chloroforming we have seen on the stage, when the victim of the villain's machinations falls unconscious after his first sniff at the fatal handkerchief. In future we shall expect thieves to arm themselves with nothing less formidable than the Vernon-Harcourt inhaler, if they wish us to believe in their diabolical intentions.

Statistics of Venereal Disease.

IT is notoriously difficult to obtain any trustworthy figures to show either the incidence or the mortality in any country of the venereal diseases. The Registrar-General's returns of mortality from syphilis cannot be relied on, for in but few cases of death ultimately due to this cause does the same appear on the death certificate. For instance, in Ireland, in the year 1903, out of 77,358 deaths registered, in only 104 is the cause given as syphilis, and in 14 as gonorrhœa. These figures obviously bear no relation to the actual facts. With regard to the extent to which venereal diseases exist in the living population, it is just as difficult to form an estimate, and the estimates that have been made are more or less guesses depending on individual experiences. Sir William Gowers is reported to have given his opinion that there are half a million people in London alone who have contracted syphilis. There are said to be 150,000 syphilitics in Berlin, and 225,000 in New York, while in France one out of every seven people is said to have the disease. Figures based on admissions to the Army can obviously not be taken as representative of the conditions of the general population, since in different countries the army is recruited from quite different classes of the population. Nevertheless, such figures are instructive, though they show a very wide variability, reaching the highest figures among British recruits and the lowest among German. Out of every 1,000 admitted to the following armies the rates for gonorrhœa and syphilis were respectively, Germany, 27 and 5·5; Russia, 36 and 13; France, 40 and 9; United States, 73 and 16·8, and Great Britain; 173 and 101. We still seem as far as ever from devising any practical means of preventing the spread of these diseases.

Changes in the Curriculum of Dublin University.

FOR some time various questions regarding the arrangement of the curriculum of the School of Physics in Trinity College have been under discussion, and we understand that a scheme has now been agreed upon which will shortly come into force. Two main objects are stated to be in view—one, more thorough training in the preliminary sciences, and the other, the prevention of undue interference by the course in Arts with that in medicine. With regard to the first point, practical courses in botany, zoology, physics and mechanics are to be added to the theoretical instruction in these subjects. The grouping of the various subjects of the course for examination purposes is to be entirely altered, and we understand that no student will be permitted to proceed to the study of one group until he has satisfied the examiners in the preceding group. With regard to difficulties supposed to arise from the Arts course interfering with medical studies, it is said that greatly increased "professional privileges" are to be granted to students of medicine. If we are not misinformed, it is proposed, in fact, to cause a practical obliteration of the Arts course, allowing students to proceed to a B.A. degree by passing an examination in medicine. Although, of course, there are good points in the scheme, the proposed changes do not on the whole appear to have a tendency to improve either the status of the Dublin degree or the value of the training given in the School of Physics. The earlier part of the medical course is, in Dublin as everywhere else, as the President of the British Medical Association pointed out the other day, already over-weighted, and if any improvement is needed in medical teaching it is on the clinical side. The lightening of the Arts course, on the other hand, is a step which is bound to have the effect of lowering the value, from a social and educational point of view, of the Dublin degree.

Registration for Nurses.

THE Select Committee that have been inquiring into the question of the State Registration of Nurses have now issued their report. A large number of witnesses have been heard, most of whom were in favour of some change being made in the conditions that now exist, though many differed as to what the change should consist in. We are glad to know that the Committee found no evidence to substantiate the assertions, freely made, that illegality, immorality, and scandal were prevalent among untrained women who take to nursing. That a certain number of undesirable characters should masquerade as nurses is of course inevitable, but the evil would appear to be one of small dimensions. Nevertheless, seeing the changes that have taken place in the conditions of nursing since it became a skilled art, the Committee recommend a central body should be formed to control nursing affairs, without interfering with untrained nurses who do not wish to continue their calling. This central body should, they think, be composed of matrons, nurses, doctors, and representatives of the public, and of the nursing schools, and should keep a register of the names of properly trained nurses. Only nurses so registered should be able to use the description "registered nurse," not a very happy term, we think, and one that might well be altered to something more distinctive and euphonious. Three years' training and a certificate that they have satisfied the authorities of their school as to their proficiency should be necessary before a nurse be registered. Moreover, the Committee hold, and in this one thing every one will agree with them, that nursing homes that supply nurses for the sick or receive patients for treatment should be registered by county or country borough authorities. It will be interesting to see how long it will take before a Bill embodying these suggestions becomes law.

The Uxorious A.M.O.

The asylum service of the London County Council is developing into a very big affair, and as the demands of the county lunatics increase it needs more and more complete organisation. Hitherto the medical staff of an asylum has consisted of a superintendent and four or five assistant medical officers, and though the interests of institutions may not be seriously jeopardised by changes among the juniors, it is absolutely necessary that the superintendent should have a permanent assistant of experience on whom he can rely when he is sick or on leave. The senior assistant medical officer has consequently become a vital factor in asylum life, and as promotion is slow he often finds himself well on towards middle age before he is selected for a superintendent's post at his own or another institution. As the position of the senior assistant carries with it fair remuneration besides the ordinary emoluments of a resident officer it certainly seems an anomaly that he should be compelled to remain a bachelor, especially as leave of absence from an asylum has to be much restricted on account of the multifarious social duties connected with the institution that fall on his shoulders. The matter has been before the Asylums Committee of the Council for some time, and last week they brought up a recommendation to the Council that the senior assistant medical officers should be allowed to marry. A good deal of opposition was encountered, chiefly on the score of expense, but the proposal was eventually adopted by a large majority. The decision is one which is in accordance with the simplest ideas of justice and prudence, and we hope we shall soon be able to publish a crop of nuptial announcements in their appropriate columns.

Moist and Dry Air.

We are so accustomed in these climates to suffer, even in the hottest weather, from excessive moisture in the air, that we usually look to dry heat as the ideal weather for summer. In doing so we are inclined to forget that, though not so unpleasant in some ways as moist heat, yet dry heat has drawbacks of a very serious nature. It is true that very rarely in temperate zones is the atmospheric air so dry as to cause serious annoyance, yet very frequently with our modern methods of heating and our lack of ventilation, indoor air becomes unpleasantly deficient in water vapour. In buildings heated by direct radiation it may happen that the air does not contain more than 20 or 30 per cent. humidity, while out of doors there is most probably 60 or 70 per cent. Such a great variation from the normal must, of course, tell on the human body in some way, and it is natural that the respiratory organs are those that suffer. When one reflects on the great expanse of moist surface in the respiratory tract exposed to the parching of very dry air, one is not surprised that the mucous membrane soon becomes dry and irritable. The result is a very unpleasant pharyngitis, with probably more or less troublesome conditions of the nares and larynx. The best remedy for this excessive dryness of indoor air is, where possible, free atmospheric ventilation through open windows. Where this is impracticable steps must be taken to provide moisture artificially by the rapid evaporation of water with the air supply.

The Price of an Eye.

In successful actions for damages for injury to the human body, a jury always has considerable difficulty in arriving at a decision as to the proper amount of compensation to be awarded. Apart from the question of the degree or nature of the injury, there are many points of great complexity to be considered. The position of the victim and the possible interference with his means of livelihood and prospects in life furnish the guiding clue in most instances, but it is scarcely to be wondered at that Courts have shown but little uniformity in their decisions. An American contemporary has collected some recent decisions of the higher American courts in cases where the cause of action was the loss of one or both eyes. The lowest compensation granted among the cases quoted was £600 for the loss of an eye, the other being slightly injured; the victim in this case was a porter. In another case a woman who had one eye destroyed in a railway accident obtained compensation to the amount of £1,400, while a young girl, a stenographer, was awarded £2,400 for total loss of sight. A man who had lost both eyes was awarded £1,800, while another, a farmer, for the loss of one, obtained £1,000. It would seem that in America two eyes are proportionately cheaper than one. This is, of course, quite irrational, as the loss of one eye may not be a matter of great pecuniary importance to the owner, while the loss of two means in most cases a termination of his active career. In this country, if we are not mistaken, a medical student a few years ago obtained a verdict for £2,000 for the loss of one eye.

Rights in Prescriptions.

IT is not often that legal luminaries adopt a sympathetic attitude with regard to the claims of medical men, so that it is particularly cheering to see an able and completely satisfactory statement as to the rights of a physician in his prescription made by a judge, even though he be an American. Judge Gaynor, of Brooklyn, in giving judgment in a case which involved the question as to whether a dispenser had a right to alter a prescription, said that a prescription was an order by a physician given to a druggist to supply his patient with a certain preparation. It should, therefore be sent to the pharmacist under seal, and after it had been dispensed should be held by the pharmacist as his warrant for having made up the particular mixture. It should always be accessible to the doctor, but to no one else. "The patient," said the judge, "pays the doctor for what he knows and is able to do for him, at the time of consultation. He does not pay for a visible and tangible prescription itself, or to any knowledge to be derived from it, neither he nor anyone else, now or hereafter, has the slightest right. The druggist who will not stand by the physician in this is not only his own worst enemy, but he is a menace to the doctor and a black sheep in his own profession." We wonder how many occupants of our own bench would, or could, have given so definite and luminous a statement on the plain rights of this plain question.

The Presidential Address to the British Medical Association.

THE Presidential Address at Leicester, delivered by Mr. Franklin, may, for eloquence and thought, take its place besides any of its predecessors, distinguished as have been many of those delivered from the presidential chair. Mr. Franklin points out what he considers three main defects in the education of the student of medicine—deficiency in the sphere of preliminary education, of obstetric medicine, and of practice of anæsthetics. The teaching of obstetrics is, outside Ireland, notoriously insufficient, and the fact is bound to tell, as Mr. Franklin says, against success in general practice. Instruction in the administration of anæsthetics is, we believe, greatly increased in recent years, and there is a satisfactory tendency to regard it as necessary that the student should have at least a good working knowledge of the subject. As for preliminary education, we fear that the tendency of the day is altogether opposite to what Mr. Franklin desires. He looks forward "to the good time coming when all medical students shall be undergraduates of a university, and shall have to take a degree in Arts." The tendency is altogether to lessen requirements as regards general education, as is perhaps natural with the present overweighted condition of the medical course proper, and even the older universities, such as Cambridge and Dublin, are gradually reducing the Arts education of their medical students to vanishing point.

The Word "Aphthous."

THE clinical condition frequently met with in infants' mouths, known as aphthous stomatitis, consists in a catarrhal inflammation of the buccal mucous membrane characterised by the appearance of herpetiform vesicles which quickly rupture, leaving minute, yellowish-white ulcers surrounded by a red areola. As far as is known, the affection is non-parasitic, and it is induced by mal-nutrition and those gastro-intestinal disorders incident to the first few months of life. Special forms of the disease, in which the aphthous ulcers run together to form large white patches, are prevalent in certain districts, and all the concomitant symptoms, local and constitutional, are correspondingly more severe. The term "aphthous" is, however, often applied in a loose way to signify any ulceration of the interior of the mouth preceded or accompanied by small white points or patches. Parasitic stomatitis, or thrush, is wrongly included under this term, for although there is generally a certain amount of inflammatory reaction present beneath the white spots characteristic of this affection, yet there is a tangible cause for the lesions in the *oidium albicans*, the presence of which may easily be demonstrated under the microscope. This variety of stomatitis is far less painful, too, than the ordinary aphthous or follicular form. As might be expected, the source of the fungus in thrush is usually to be found in dirty feeding-bottles. At a recent meeting of the Société de Pédiatrie, of Paris, a discussion took place with regard to the use of the word "aphthous" in medicine, and the majority of the members considered that the term should only be employed in a subjective sense—*i.e.*, when pain and inflammation predominate. It would certainly be advisable to avoid the word when speaking of true parasitic stomatitis.

Liability for Poisoning.

FOLLOWING as it does on certain recent actions for damages which will be fresh in the minds of our readers, a decision given by Judge Edge in the Clerkenwell County Court on August 2nd will strengthen the hands of those who desire to see greater care given to the question of food supplies. A widow, living at Islington, brought an action for damages resulting from the death of her son against a fishmonger who had supplied him with some eels for stewing, whereby he was afflicted with ptomaine poisoning, from which he died. The Judge, in awarding her £40 damages and costs, remarked that the case raised most important questions, not only for the defendant, but for all people who supplied food to the public. There was no negligence on the defendant's part, but he must be held to warrant food that he sold to the public as good and wholesome, as was provided for by the Food and Drugs Act and the Sale of Goods Act. In the case in question the deceased had relied on the defendant's expert knowledge to provide him with what was good and wholesome, and therefore he was entitled to expect a trustworthy article. That the defendant had presumably done his best and failed did not prove either a bar to action or a good defence, and the mother was entitled to damages for loss of her son's services. Actions of this kind ought to be brought widely to the knowledge of people, for if all cases of illness caused by food were made the subject of civil actions, food purveyors would soon take special precautions against adulteration and contamination. An epidemic of poisoning that could be traced to an ice-cream vendor, for example, would spell ruin to the purveyor if all the victims sued him for damages.

Transfusion Dangers.

In last week's issue of The Medical Press and Circular, page 118, we commented upon the fact that common salt may, under certain circumstances, act as a poison within the body. The use of normal saline solution for purposes of transfusion, whether intravenous or subcutaneous, has become so general that hardly any doubt has been raised, hitherto, as to its beneficent influence in cases of shock or collapse. The question appears to be not merely whether such and such a fluid possesses any deleterious effects upon the red blood-corpuscles, but rather if it be isotonic or otherwise with the blood-plasma. Dr. A. P. Beddard, in a clinical lecture recently delivered at Guy's Hospital, reviews the whole subject of transfusion, together with the various methods employed and the dangers that may be encountered in its performance. Theoretically, it is stated that a 5·8 per cent. solution of pure dextrose is perfectly isotonic with blood-plasma. This substance is best introduced into a vein, especially in conditions of uræmia and loss of fluid from the vascular system. The majority of sodium and potassium salts have more or less poisonous properties, and ordinary salt solution, as commonly employed for transfusion, is more toxic than a solution of dextrose, particularly in those toxæmias in which the patient has not lost a large quantity of salts from the vascular system. One case is narrated in which sodium bicarbonate was used intravenously for diabetic coma, the object of the alkali being to neutralise the effect of the acid intoxication met with in this condition. Severe pyrexia ensued, the temperature reaching 109·5° within half an hour of death. The danger of sepsis from continuous transfusion, especially in diabetics, is pointed out, as well as the risk of overdistending the right heart from an intravenous injection given too quickly. The subcutaneous route appears to be the best in most cases in which this method of treatment is called for.

The Changes in the Final Examination of the Royal University of Ireland.

The changes which we recorded last week as having been made in the examination for the medical degrees of the Royal University of Ireland will, we believe, be welcomed by both students and examiners. The examination in the past has on the whole been an excellent one, but it has been unduly extended, and we have heard many complaints of candidates having reached such a stage of mental and physical exhaustion by the time the last day was reached as to be quite unable to do justice to their knowledge. An attempt was made to correct this fault at the spring examinations of the present year, and students were for the first time allowed to decide beforehand whether they would present themselves for a "pass" or for an "honour" examination. This arrangement seemed at first to offer an advantage over its predecessor, but when put to the test of practice it completely broke down, and was censured alike by student and examiner. By the new arrangements, the pass examination will be held exactly as heretofore, but two important changes have been introduced into the honour examination. In the first place candidates will be allowed to specialise in honours, and to present themselves in one or more of three groups :—Medicine and allied subjects, surgery and allied subjects, midwifery and gynæcology. In the second place, the honour examination will be entirely a written examination. In assessing the honours, the entire marks obtained by the candidate at the pass examination in the particular groups he has selected, together with the marks obtained at the honour examination, will be taken into account. Exhibitions will be awarded, having regard to all the marks obtained at both the Pass and Honour Examinations. The scheme on the whole very closely corresponds with what has been known to be the opinion of the examining board for some time, and we believe it will be well received by examiners.

PERSONAL.

The presidency of the Medico-Legal Society has been accepted by Sir Joseph Walton, one of His Majesty's Justices of the Supreme Court in succession to Sir William J. Collins, the first President.

Surgeon-General Sir Benjamin Franklin, K.C.I.E., late Director-General, Indian Medical Service, has been appointed a Knight of Grace of the Order of St. John of Jerusalem in England.

Dr. Chalmers Watson, Edinburgh, has been awarded the Alvarenga Prize of the College of Physician of Philadelphia, for an essay on "The Importance of Diet: an Experimental Study from a New Standpoint."

Mrs. Thomas Wharrie has given a generous donation of £5,000 to St. Mary's Hospital, and the late Miss Agnes Abercrombie £1,000 to the Edinburgh Royal Infirmary.

Dr. Alfred Eddowes, of London, has been elected a corresponding member of the Société Française de Dermatologie.

Dr. John E. Jones, of Washington, has been appointed by President Roosevelt to be United States Consul at Dalny, in Manchuria, which is now in the hands of the Japanese.

Dr. Jamieson, the South African Premier, arrived last Saturday at Southampton. He is reported to be suffering from an attack of carbuncle, which make it necessary for him to cancel all engagements before proceeding to Carlsbad.

The late Sir John Willox, editor and proprietor of the *Liverpool Courier* has bequeathed to the Royal Infirmary, the Southern Hospital, and the Stanley Hospital, Liverpool, each £10,000. £10,000 is also bequeathed to the sanatorium in Delamere Forest, to be invested to form what is to be known as the "Lady Willox Endowment Fund."

Capt. N. J. C. Rutherford, Royal Army Medical Corps, from Capetown, has been appointed to the London district from September 1st.

The President of the Royal College of Physicians, London, announced that the Bradshaw Lecture on Exophthalmic Goitre and its Treatment, would be delivered by Dr. G. R. Murray, on November 7th; and the FitzPatrick Lectures by Dr. Norman Moore on November 9th and 14th. The subject of the first lecture would be, John Mirfield (1393) and Medical Study in London during the Middle Ages.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

The Chair of Midwifery in Edinburgh University.—The University Court has decided to institute a lectureship in gynæcology, and to proceed to the appointment of a Professor of Midwifery. The duties of the Professor and Lecturer will be adjusted by the University Authorities, on consultation, we presume, with the managers of the Infirmary and Maternity Hospital, for it is to be supposed that the new Professor will, like his predecessors, have a post on the staff of the latter institution and that the University ward for the Diseases of Women will be placed under the charge of the new Lecturer. Applications for the posts with testimonials, must be in the hands of the Secretary to the Curators of Patronage, Mr. R. Herbert Johnstone, W.S., 4, Albyn Place, Edinburgh, on or before Friday, September 15th next.

Graduation Ceremony, Edinburgh University.—Unusual interest attached to the summer graduation of 1905, which was held on July 28th, because it was the occasion of Professor Simpson's farewell to the University in which he has laboured so long. The promoter entitled his address "Religio Obstetrici," and, after alluding to his resignation, Professor Simpson went on to speak of the changes which had taken place, of the progress that had been made, since his student and apprentice days. When he began to lecture there was one German obstetric journal, none in French; now he saw six German and six French, besides Italian, Roumanian, Russian and Japanese. When he began to study the system of apprenticeship had not quite died out, and it was his good fortune to be apprenticed to John Goodsir; since then the examination system had grown up till it had become a mulitiplied misery. The archaic examinations of the speaker's early days were then referred to—how he got his degree with two written examinations of two days each, and an oral examination of the simplest. Again, in Professor Simpson's studentdom an interchange of Professors among the various chairs took place to an extent impossible now. Sir Douglas Maclagan taught materia medica, then Medical Jurisprudence, and was also a clinical teacher. When Alison resigned the chair of medicine Sir James Young Simpson was urged to become a candidate. When Laycock got the chair of Medicine against Wood, the latter threatened to teach midwifery in opposition to Simpson, while Traill was reputed to be able to take the place of any colleague who was ill—only drawing the line at the class of clinical surgery. Of the factors in the advance of science during his lifetime the two chief were the extended range of observation opened by the spectrum and electricity, and the guidance given to imagination by the doctrine of evolution. In seven paragraphs the speaker tried to reproduce the transformations of thought he had been made to see:—1. Ether, conceived as a fluid, the fundamental of matter, which displays itself under the influence of force or energy. 2. The earth has grown old—the 6,000 years of its boyhood had changed to thousands of ages. 3. He used to be taught that in six days it had got its final and fixed form; now it was still in the making. 4. The elements are dissolved, and now we seemed to have come to the borderland where ether clothed itself with matter, when the mutation of one element into another may take place. 5. The unit of biology has been transformed from the cell to the chromosome and nuclear elements. 6. Life is continuous. 7. The germ plasm eternal. The address concluded with the following eloquent peroration. "It may chance that some July day far down the century, when I have long been in the ether, one or other of you will talk with child or grandchild of the years when the century was young. Among its unforgotten scenes there will rise before your mind the memory of the day when at last you burst the chrysalis shell of pupilage to lift free ways into the azure. You will recall the unusual concurrence of the simultaneous leave-taking of the University by the graduates and their promoter. 'We came away,' you will say, 'a goodly company, together, through the gateway that leads to the rosy dawn. He passed out, all alone, through the door that looks to the sunset and evening star. He was an old man like me,' I forehear you say. 'Not in himself a great man, he had been the friend of great men, and came out of a great time in the 19th century, "when there was midsea and the mighty things," and it looked to the men of his generation as if old things had all passed away and a new world begun. And he told us that the great lesson he had learned through life was the same that the disciple who leaned on Jesus' breast at supper taught to the fathers, the young men, and the little children of his time, when he said "The world passeth away, and the lust thereof; but he that doeth the Will of God abideth for ever."' Farewell."

When Professor Simpson had concluded, Mr. Norman, President of the Students' Representative Council, presented an address to the retiring Professor, and the Vice-Chancellor paid a tribute on behalf of the Senatus. The proceedings were concluded by the benediction pronounced by Prof. Taylor.

BELFAST.

Down District Asylum.—The annual report of this institution has just been published by Dr. Nolan, the resident medical superintendent. The admissions during the year were 179, 99 males and 80 females, and the discharges were 84, 36 males and 48 females, while 58 patients died. The daily average number of cases under treatment was 673, comprising 370 males and 303 females, and the average cost of maintenance of each patient for the year, calculated on the gross expenditure, less repayment of loans, was £24 4s. 7d., as against £25 4s. 2d. for the previous year. Deducting receipts from paying patients, capitation grant, &c., the actual cost of maintenance on the local rates stands at £7 15s. 8d.

The Water Supply in Ulster.—The heavy fall of rain last week was very welcome in Ulster, as in a number of the small towns the water supply was almost exhausted. In Larne and Holywood the condition of affairs threatened to become very serious, and much inconvenience was experienced. In the latter town a medical practitioner called out to an emergency operation at night could obtain no water to boil his instruments in!

Health of Belfast.—During the four weeks last reported there were 158 cases of zymotic disease notified in Belfast, and 62 deaths were registered from the same causes. Typhoid has diminished, there being 32 cases, and only one small-pox case occurred. There is an epidemic of measles at present, and 17 deaths occurred from it, while 26 deaths were attributed to diarrhœa. There were 104 deaths in children under one year old, equal to a rate of 3·7, while the total death-rate was 17·1.

OPENING OF A NEW OPERATING THEATRE IN CORK.

On July 20th, in the presence of a large gathering of friends and supporters of the Hospital, a new operating theatre was opened at the North Charitable Infirmary. The new block consists of the theatre proper, an anæsthetic room, a sterilising room, and a preparation room. The theatre contains the most recent improvements, and is heated on the Plenum system. Professor Pearson, in the course of a short statement as to the origin, nature and arrangement of the building stated, that in response to an appeal from him, the theatre had been presented to the Infirmary by Miss Belle Honan. On the proposal of Mr. Harding, J.P., a vote of "sincere and grateful thanks to Miss Honan for her munificent gift" was adopted with acclamation, and shortly afterwards the proceedings terminated.

Obituary.

THOMAS BOLES EAMES, M.R.C.S.Eng., L.R.C.P.Ed.

The death of Dr. Thomas Boles Eames, of Welford-on-Avon, formerly a well-known practitioner in the neighbourhood of Farnworth and Kearsley, will be greatly regretted by those who once enjoyed his servces as doctor and friend. He completed his eighty-third year in January last, and received his education at Cork, afterwards studying medicine in Dublin. He became a member of the Royal College of Surgeons of England in 1845, and in 1859 he obtained the Licence of the Royal College of Physicians of Edinburgh. Besides having a practice covering a district extending as far as Ainsworth, Little Hulton, and Clifton, he was club doctor at the old Prestolee Cotton Mill. He was President of the Bolton Medical Society about 1878, and was one of the founders of the Manchester Medico-Ethical Association.

Correspondence.

DR. WALSH'S METHOD OF SCALP-ISOLATION OF RINGWORM.

To the Editor of The Medical Press and Circular.

Sir,—With regard to Mr. Pearse's annotation in your last issue as to the use of the biniodide of mercury in ringworm. I can endorse its value in some cases. But, like all other remedies claimed as specifics, its failures far outnumber its successes. That point was carefully emphasised by Dr. Walsh in his important communication. His aim was to advocate not any particular method of cure but rather to describe a practical method of prevention. What is that plan? It is, briefly, to substitute local for general isolation; to isolate the affected scalps where it would be impossible to isolate the children bodily. By a happy chance it comes about that the systematic removal of the adherent cap-film shortens the period of treatment. The essential triumph of Dr. Walsh's procedure is that it enables children affected with ringworm to attend school with impunity. Of course, there is nothing new in the application of medicated collodion, but the masterly idea of general adoption of scalp isolation is original, and, to my mind, final. The London County Council can hardly consider the future of school ringworm apart from the suggestion to start central institutions for the systematic treatment of public education scholars by scalp isolation.

I am, Sir, yours truly,
A Senior Dermatologist.

London, August. 3, 1905.

Literature.

MERCK'S ANNUAL REPORT FOR 1904.

The excellent annual report on the therapeutic advances of each twelve months published by Messrs. Merck and Company, now occupies an established position in medical literature. Although issued by a manufacturing firm it maintains throughout a spirit of absolute impartiality. The work is extensively used as a book of reference, but is hardly as widely known as it deserves to be amongst medical men who are interested in scientific pharmacy and therapeutics. The field of knowledge opened out in this way by modern research appears to be well-nigh illimitable. Much of the literature that is published on the subject hails from interested quarters, while a good deal more must be regarded as simply of a hasty, tentative, and fleeting origin. Under such circumstances it is of importance to be furnished with a trustworthy key in which scientific accuracy and simple directness of statement are the essential features. Personally, we have found Merck's little volume a handy and convenient book of reference.

Pass Lists.

Army Medical Service.

The undermentioned candidates were successful at the recent competitive examination in London for Commissions in the Royal Army Medical Corps, and for which sixty candidates entered. Names are arranged in the order of merit:—John Allan Anderson, M.B., Ch.B.Ed., Cuthbert G. Browne, M.R.C.S.Eng., Hugh Godwin Sherren, M.R.C.S.Eng., Henry Horace Andrews Emerson, M.B., B.Ch.Dub., Wallace Benson, M.B., B.Ch.Dub., Rowland Philip Lewis, M.R.C.S.Eng., George Edward Ferguson, M.R.C.S.Eng., James Herries Graham, M.B., B.S.Dur., Charles Ernest White Spinner Fawcett, M.B., B.Ch.Dub., Thomas Scatchard, L.S.A.Lond., Ronald Anderson Bryden, M.R.C.S.Eng., Arthur Edmund Stewart Irvine, L.R.C.P.&S.I., Thomas Bettesworth Moriarty, L.R.C.P.&S.I., Alexander Macgregor Rose, M.B., B.S.Aberd., Edward Lawton Moss, M.R.C.S.Eng., Edward Guy Anthonisz, M.R.C.S.Eng., Griffith Henry Rees, M.B., B.S.Lond., M.R.C.S.Eng., Vivian Hood Symons, M.R.C.S.Eng., Walter John Weston, M.R.C.S.Eng., Mortimer John Cromie, M.R.C.S.Eng., Percy Farrant, M.R.C.S.Eng., Albert Edward Francis Hastings, L.R.C.P.&S.I., George William Webb Ware, M.B., B.Ch., R.U.I., Michael Balfour Hutchinson Ritchie, M.B., B.S.Aberd., James Stuart Dunne, F.R.C.S.I., William McConaghy, M.B., B.Ch.Ed., Francis Cornelius Sampson, M.B., B.Ch., R.U.I., Charles Francis White, M.B., B.Ch., R.U.I., Cecil John Wyatt, M.B., B.Ch.,Dub., Wilfrid Cowan Nimmo, M.R.C.S.Eng., Edmund Thurlow Potts, M.D., Ch.B.Ed., Michael Keane, L.R.C.P.&S.I., Arthur Drought O'Carroll, M.B., B.Ch.R.U.I., Robertson Stewart Smyth, M.D., B.Ch.Dub., Arthur James Arch, M.R.C.S.Eng., Thomas Somers Blackwell, L.R.C.P.&S.I., Harold Edgar Priestley, M.R.C.S.Eng., Alan Cuncliffe Vidal, L.R.C.P.&S.Ed., Philip Jauvrin Marett, M.R.C.S.Eng., Hugh Stewart, M.B., B.Ch.

Notices to Correspondents, &c.

☞**Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Club Doctor (Blantyre).—There are no new developments in the relations existing between friendly societies and medical men in Coventry, save that it is an almost foregone conclusion that the 4s. 4d. instead of 3s. asked per member will probably be refused. Some of the doctors are of opinion that children should pay more than adults, as they require three times as much attendance.

Dr. H. (Sydenham).—Under the new regulations of the L.C.C. Board of Education vaccination is not compulsory for pupil teachers until they come under the Board of Education. The pamphlet issued by this Board on Education in Hygiene and Temperance, issued by the L.C.C., can be had at the Embankment offices of the London School Board.

M. L.—The use of the tetanus antitoxin has not proved successful in all cases. But the value of it is shown by the fact that mortality in the disease is reduced from 90 to 59 per cent.

AN ANTIENT REMEDY.

She bore hym in her arms, and hurried too a Rheum, where he mite be quiet, gave hym bred and meet, held a cent bottel under hes knows, untide neckerchef, rapped hym up warm and gave hym a suite drachm.
—*St. Nicholas.*

Dr. H. R. S.—You will find the monthly proceedings of the Midwives' Board duly reported in our columns. The last report appeared in our issue for August 2nd.

Mr. R. S. Moss is thanked for his communication, which he will see has been utilised.

D. P. H.—The sanitation of restaurant kitchens is a question which cannot be brought up too often. We agree with you that an authoritative inspection would secure a plentiful crop of unpleasant revelations.

Practitioner.—Personalities of a virulent type under a pseudonym would hardly be accepted in this journal. We therefore return your letter sent for publication.

Mr. H. Murdock.—The subject is under investigation. Report will be made in due course.

Fifth Year.—We understand that a new edition is in the Press of the book referred to.

Vacancies.

Royal Surrey County Hospital, Guildford.—House Surgeon. Salary £100 per annum, with board, residence, and laundry.—Applications to the Hon. Secretary at the Hospital.

Royal Surrey County Hospital, Guildford.—Assistant House Surgeon, Salary £50 per annum, with board, residence, and laundry. Applications to the Hon. Secretary at the Hospital, on or before Monday, August 14th, 1905.

Royal College of Surgeons in Ireland.—Senior Demonstrator in Anatomy. Salary £100 per annum. Applications to G. F. Blake, Registrar.

Royal National Sanatorium, Bournemouth.—Resident Medical Officer. Salary £10 per month, with board, residence, and washing. Applications to the Secretary.

Bury Infirmary.—Senior House Surgeon. Salary £110 per annum, with board, residence, and attendance. Applications to Honorary Secretary, Dispensary, Knowsley Street, Bury, Lancashire.

Exeter City Asylum.—Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Digbys, Exeter.

Roxburgh District Asylum, Melrose, N.B.—Assistant Medical Officer. Salary £140 per annum, with board, rooms, &c. Applications to Medical Superintendent.

Royal South Hants and Southampton Hospital.—House Physician. Salary £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher-Hall, Secretary.

Royal Victoria Hospital, Bournemouth.—A House Surgeon. Salary £100 per annum, with board and lodging. Applications to the Secretary.

Noble's Isle of Man Hospital and Dispensary, Douglas, Isle of Man.—Resident House Surgeon. Salary £90 a year, with board and washing. Applications to Richd. D. Gelling, Honorary Secretary, St. George's Chambers, Athol Street, Douglas, Isle of Man.

The Municipality of the Town of Singapore, Straits Settlements.—Assistant Health Officer. Salary £400 per annum. Applications to C. C. Lindsay, Esq., M.Inst.C.E., 180, Hope Street, Glasgow.

Appointments.

Clay, Robert Hogarth, M.D., M.R.C.P.,Edin., Hon. Medical Adviser to the Devon and Cornwall Home for Consumption, Didsworthy.

Collier, H. W., M.B., B.S., Clinical Assistant to the Chelsea Hospital for Women.

Corbett, W. E. Manderson L.R.C.P. and S. Irel., Honorary Medical Adviser to the Devon and Cornwall Home for Consumption, Didsworthy.

Jackson, George, F.R.C.S.Eng., L.R.C.P.Lond., Hon. Medical Adviser to the Devon and Cornwall Home for Consumption, Didsworthy.

Lindsey, Colin Dunrod, M.A., M.D., B.C., D.P.H.Cantab, Hon. Medical Adviser to the Devon and Cornwall Home for Consumption, Didsworthy.

Maurice, W. B., M.R.C.S., L.R.C.P., Clinical Assistant to the Chelsea Hospital for Women.

Robinson, W. L.R.C.P., L R.C.S., Clinical Assistant to the Chelsea Hospital for Women.

Taylor, Mark Ronald, L.R.C.P.Lond., M.R.C.S., Medical Officer of Health of Helston, Cornwall.

Toye, Edwin Josiah, M.D., B S.Lond., F.R.C.S.Eng., L.R.C.P.Lond., Medical Officer of Health for the Northam (Devon) Urban District Council.

Webber, H. Woolmington, M.D., M.S.Lond., F.R.C.S.Edin., Hon. Medical Adviser to the Devon and Cornwall Home for Consumption, Didsworthy.

Woollcombe, Walter Ley, F.R.C.S.Edin., M.R.C.S., L.R.C.P.Lond. Hon. Medical Adviser to the Devon and Cornwall Home for Consumption, Didsworthy.

Wright, Edward Arthur, M.B., M.S.Edin., Hon. Consulting Surgeon to the Huddersfield Infirmary.

To the Richmond, Whitworth, and Hardwicke Hospitals the following appointments have been made:—House Surgeon, Dr. H. R. C. Rutherford; House Physician, Dr. J. W. Houston.

Births.

Legge.—On August 6th, at 18, Cheyne Row, Chelsea, the wife of Thomas M. Legge, M.D., of a son.

Pollard.—On August 4th, at the Royal Naval Hospital, Chatham, the wife of Inspector-General E. R. H. Pollard, R.N., of a daughter.

Marriages.

Bruce—Helm.—On August 3rd, at St. Mary the Virgin, Penzance, the Rev. J. Collingwood Bruce, son of the Right Hon. Sir Gainsford and Lady Bruce, to Bertha Helm, daughter of the late George F. Helm, of Marazion, Cornwall.

Scott—Wilson.—On August 3rd, at St. Bernard's Church, Edinburgh, Wm. Thurburn Scott, M.B., second son of Russell Scott, Shoreham, Kent, to Frances Wilson, youngest daughter of John Wilson, Castle Park, Huntly, N.B.

Deaths.

Beck.—On August 3rd, at the North-Western Hotel, Dublin, Eleanor Eliza (Nellie), of Queenstown, formerly of Kingstown second daughter of the late Surgeon Herbert Browne Beck, of Bermuda and Alderney.

OPERATIONS—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopædic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9 30 a.m. and 2 30 p.m.), Gt Ormond Street, 9.30 a m.), Gt. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p m), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynæcological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Spuare (9.30 a.m.), City Orthopædic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St George's (1 p.m), St. Mary's (10 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.35 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynæcological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopædic (2 p.m.), City Orthopædic (4 p.m.), Great Northern Centre (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, AUGUST 16, 1905. No. 7.

Original Communications.

THE HIGH INFANTILE MORTALITY RATE,

THE FAR HIGHER INFANTILE DETERIORATION RATE, AND THE MEANS TO CHECK THEM. (*a*)

By GEORGE CARPENTER, M.D.LOND.,

Editor and Founder of the *British Journal of Children's Diseases*; Physician to the North-Eastern Hospital for Children; Medical Officer of Health for Beckenham; formerly Physician to the Evelina Hospital for Sick Children.

THE Registrar-General's returns for 1904 show that the average death-rate for the seventy-six great towns of England and Wales was 17·2 per 1,000, while the infantile mortality rate of children in the first year of life was 160 per 1,000 births. In 142 other towns it was 154 per 1,000, and for rural England and Wales 125 per 1,000. Certain other large towns showed a still larger rate: thus, Birmingham was 197; Liverpool, 196; Stockport, 203; Hanley, 212; Preston, 218; and Burnley, 229. In London the highest borough rate was that of Bermondsey, which was 172, and the lowest was Marylebone, with a total of 94.

The infantile mortality rate in the various wards of Birmingham has been shown to be no less than 331 for St. Mary's, and 263 for St. Bartholomew's, the least being 133 for Edgbaston and Harborne; and there is reason to believe that selected districts in other large towns would show equally startling figures.

Of provincial towns Bournemouth was 111; Hastings, 108; King's Norton, 100; and of London suburbs Willesden, 114; Beckenham with the low general death-rate of 9·1 was no less than 126.

There can be no question from a study of these startling national statistics that the infantile death-rate is excessive, and a standing menace to the country. Further, this waste of infant life is a class mortality—it is practically confined to artisans and the labouring classes, and does not exist to any serious extent in the upper and middle classes. Although in the upper and middle classes infantile lives are not in such jeopardy, the infants born to these classes are very prone to diet disorders and suffer thereby through life from the lack of vigour—physical wrecks in sequence to readily preventable conditions. During the past decade the birth-rate in the United Kingdom has steadily diminished. Had it not been for the alien immigrant the actual population of England would have decreased.

The infantile mortality question is one, therefore, of extreme importance, not only in relation to the growth of the population, but in regard to the physique of the nation. While thousands perish outright, hundreds of thousands who worry through are injured in the hard struggle for existence and grow up weaklings—physical and mental degenerates. A high infantile mortality rate therefore denotes a far higher infantile deterioration rate, and this unwelcome fact must not be lost sight of.

Of all the causes, and they are numerous, which lead to this large sacrifice of infant life, and to the undermining of the infant physique, food is the most important. Improper feeding is mainly responsible for infantile deaths and disease. Three-fourths of the deaths of children under 12 months of age occur among those who are bottle-fed. This enormous mortality and widespread production of disease can be largely prevented by breast-feeding, and failing maternal nursing, by the use of *pure* cow's milk in suitable dilution. Of the two methods, the former, or Nature's method, is the only one that can be recommended. The latter is to be viewed merely in the light of a makeshift. The large majority (75 per cent.) of mothers are capable of nursing their children, though in the upper classes the percentage that perform their maternal duties in this respect is very small indeed.

Von Bunge, of Bâle, asserts that a deficiency in maternal milk is due to the imbibing of alcohol by the parents. His statistics, drawn from all Europe, show that women with an insufficient supply of milk are usually the daughters of alcoholics. He asserts that if two generations have been alcoholic the women of the third generation will almost certainly be unable to nurse their children. The importance therefore of alcoholic temperance in indirect relation to infantile mortality is obvious.

A number of poor women, by reason of their having to find employment in mills, factories, warehouses, and elsewhere, are unable to nurse their children, and certain others fail in this respect owing to ill-health and lack of sufficient nourishment. The Factory Act provides that a woman shall not be employed within four weeks of child-birth. To ensure the carrying out of this Act, *ten* ladies are employed throughout the United Kingdom. Comment is not necessary. It would be a source of great protection to infant life and health if suckling mothers were not allowed to leave their infants to follow their employments. Women who can nurse should be encouraged to do so, for therein lies the secret of a healthy and peaceful infancy and a vigorous childhood and manhood. Steps should be taken to impress upon mothers the importance of performing these maternal duties for the sake of their own health as well as for that of their offspring. They must be taught that breast milk is the proper food for the child, and that there is no substitute for breast milk. The term "humanised milk" should be abolished; mothers are misled thereby, and are apt to assume that "humanised milk" is just the same and just as good as breast milk, and that it can be used in the same way.

To popularise maternal nursing among the poor, it would be well to institute local charitable societies for the award of prizes to the most successful mothers and for the payment of gratuities, or for the provision of nourishment where necessary to enable mothers

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(*a*) An Address delivered at the London Congress, Royal Institute of Public Health, Section Child Study and School Hygiene, July, 1905.

to properly carry out their duties. The societies would also, through their medical officers, look after the health of mothers during lactation, and would instruct those about to become mothers as to the best way to preserve their health during pregnancy and to bring forth healthy offspring at term.

Where breast-feeding is impossible or can only be partially undertaken the rearing of the infant by artificial methods becomes necessary, but not until then. For this purpose cow's milk is the substitute.

The bottle-fed infant requires *pure* uncooked cow's milk, suitably diluted according to its age, and it should be the aim of municipalities to provide nurslings and others with a commodity which is above suspicion, and not with a product so filthy that sterilisation becomes imperative. (*a*) Certain municipalities, following the lead of the Societies of the Gouttes de Lait of France—to wit, Liverpool, Battersea, Leith, St. Helen's, Glasgow and others—recognising their duties towards the infant population, have endeavoured to reduce the infant mortality rate by supplying sterilised milk at milk depots. While one cannot but applaud their noble efforts in aid of suffering infantile humanity, one cannot but feel that their methods are faulty. From the financial side they have not as yet proved remunerative, as they are not very popular. So far they appear on paper to have been fairly successful in their aim—the reduction of infant mortality. Thus, the mortality rate of the depot-fed infant appears to be decidedly less than that of the general infantile mortality rate of the towns in which the depots are situated. The numbers are, however, too small to draw any reliable deductions therefrom, and there are other fallacies.

There are two great objections to milk sterilised at the depot. One of them is that boiling milk does not destroy the poisonous products which the bacteria have produced in transit, though cooking is inimical to the microbes. The other objection is that milk so treated is apt to produce scurvy, anæmia, and malnutrition in the nursling. In the May, 1904, issue of the *British Journal of Children's Diseases*, in an editorial under the heading of "Municipal Milk Supplies," it was pointed out that sterilising, humanising, &c., are means employed by medical men for special reasons and for a limited period; but they produce such changes in the milk that their employment on a large scale and apart from medical advice is not justifiable. Further it was stated: "We have the greatest respect for the medical officers of health in this country when carrying out their own work, but the feeding of infants is rather outside their sphere and is a branch of medicine in which few of them have had any special training or experience. Their statistical results as to feeding by municipal milk form most interesting reading, but we are not prepared to accept them as finally settling problems which have exercised and are still exercising all the skill of specialists in diseases of children. The effects of a dietary on a large number of infants can only be correctly estimated by those who have had the children directly under their own observation. Statistics as to the death-rates of infants fed on municipal milk, and others not so fed, are practically worthless, because so many unknown factors come in."

Municipalites have a great work before them, viz., the stiffening of the present regulations under which milk is produced, carried by cart and rail, and stored and delivered to the customer. The speedy formation of some central authority—a special Government Department—is required to formulate stringent regulations and to efficiently control the milk trade of the country. From the time the milk leaves the ill-kept cows and its passage over the manure-begrimed hands of the milker until its arrival at the customer's dwelling it receives but scant attention saving that of the unscrupulous dealer, who, by various injurious chemical adulterations—boric acid and other deleterious drugs—retards decomposition for a time.

Regulations are required to compel—

(1) The grooming of milch cows, the keeping of their bodies sweet and clean, and ablutions of their teats and udders before milking.

(2) The suitable feeding of milch cows.

(3) The proper stabling and bedding of milch cows.

(4) Cleanliness of cow tenders and milkers and the suitable clothing of the latter when milking.

(5) The aseptic conduct of milking operations.

(6) Suitable treatment of the milk during and immediately after milking.

(7) The subsequent transference of the milk to suitable glass or other stoppered receptacles, and the appropriate treatment of these receptacles when not in use. Investigations recently undertaken by Dr. G. H. Steward, of the Philadelphia Bureau of Health, show that specially prepared paper bottles can be used with advantage for this purpose. Bacteriological tests showed that the milk in the paper bottles contained fewer bacteria than that in the glass receptacles—on an average about one-fourth—and the milk kept sweet two days longer. The cost of the bottles is trifling and the price of the milk is not increased by their use, and when emptied they can be thrown away.

(8) The better and more rapid transit of bottles of milk to and by rail in refrigerator vans and the speedy abolition of the milk-churn.

(9) The storage of milk in stoppered bottles on ice or in specially chilled receptacles in the milk-shops.

(10) The delivery of chilled milk to the customers in stoppered bottles by special refrigerator carts.

(11) The municipalities, in addition to the ordinary methods of chemical analysis, should undertake frequent bacteriological examinations. The number of microbes per cubic centimetre should be estimated, and also the percentage of lactic acid in the milk, so as to control not only obvious additions and subtractions, but also the methods of collection as regards cleanliness.

(12) Increased powers are required to enable milch cows to be tested by tuberculin.

(13) The dispensing at the farm, under municipal control, of uncooked milk in simple dilutions of appropriate strength for infant feeding, according to age, to be placed in stoppered bottles, each bottle to contain sufficient for one feed, and a suitable number of bottles to be supplied for a day's consumption, and packed in appropriate wicker baskets or other receptacles. Printed instructions, in simple language, in regard to infant feeding should accompany the baskets.

(14) To prevent the abuse of the municipal milk depot and the encouragement of bottle-feeding the milk should be supplied to the customer only on a doctor's order.

It is important that provision should be made for the municipal-milk-fed infant to be reared *under medical guidance*, and that the progress made by the infant should be registered weekly, so that its feeding can be scientifically controlled and modified whenever necessary, and its health be supervised. Municipalities should not seek to make themselves responsible for infant feeding, in regard to which they possess no qualification, but rather should they devote their attention to the provision of a *pure* commodity—a necessity for young and old alike.

To obviate the milk depot being turned into an out-patient department, arrangements might be advantageously made with the children's hospitals or other hospitals to undertake the work of the depot for the localities in which they are situated. This plan would insure skilled medical attendance by recognised children's specialists and would help to popularise the movement. The sanitary and financial control would remain in the hands of the public health authorities as at present and the medical arrangements would be supervised by those who are best able to advice on such matters. Such a system would prevent

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(*a*) *Vide* Editorial: "The Milk supplied to Infants," *British Journal of Children's Diseases*, February, 1904; also Editorial: "Milk Dispensaries for Children's Hospitals," *ibid.*, March, 1904.

friction with hospital authorities and local practitioners; and would prove a very powerful combination for good. This plan would give the children's hospitals an opportunity of obtaining that for which there is so great a need at present—a *pure*, wholesome, uncooked food.

The present system of administering out-patient relief at the children's hospitals and at other hospitals where infantile disorders are treated is unsatisfactory. The infantile mortality rate of those attending these departments is large, and this is the case because it is most difficult, for a variety of reasons, to carry out a treatment on these patients.

The majority of the infants are brought for dietetic disorders. The physician readily detects the nature of the ailment and suitably prescribes, but the power to assist mostly ends there. If the illness be due to dietetic errors, the mother is given a paper of instructions along with a prescription. The directions for feeding are good, but the giving of the paper to the mother is not sufficient for the end in view. The bottle of medicine is considered the most important outcome of the hospital visit; it is tasted and sampled with approval or the reverse by the mother and her acquaintances, but the printed instructions are crumpled up and often mislaid before the hospital precincts have been left. In these cases, to be able to prescribe a suitable clean milk mixture would be a great boon to the doctor as well as to the infant.

A year or so ago I advocated the creation of Milk Dispensaries (*a*) for the dispensing of pure milk and pure diluted milk in connection with the children's hospitals, particularly in connection with the North-Eastern Hospital for Children, Hackney Road. The House Committee of the Hospital and their chairman (Mr. C. J. Port) favourably viewed the idea. The difficulty of obtaining a *pure* milk was quickly discovered when the matter was gone into and the leading dairies were visited; and there was some hope when this state of affairs was recognised that the Hospital, either alone or in combination with other similar institutions, would be able to manage a dairy-farm on the most approved modern principles for the supply of milk. Lack of funds for the purpose and important building works on hand prevented the fruition of the scheme, and the infantile out-patients are still in want of a prime necessity for their successful treatment, viz., *pure milk*. It was proposed that milk should be paid for by those patients who could afford to purchase it, and that it should in deserving cases on inquiry by the almoner be supplied below cost price.

In connection with the children's hospitals there should also be some system whereby the treatment of out-patient infants could be carried on at their homes. Such a plan would preserve many infantile lives to the nation, and improve the national physique. An efficient visiting nursing staff for local cases is a necessary part of a children's hospital equipment. The nurses' duties would be to superintend the carrying out of the physician's directions, and to give practical instruction in simple hygiene and the domestic duties incumbent on women and mothers. These nurses should be required to have been thoroughly trained in a children's hospital, and to be well grounded in all domestic duties.

They could either be in the hospital employ, or their services—if in the future a municipal milk depot is to be a part of a children's hospital equipment—might be obtained on application to the municipal authority in whose pay they would then be. For the creation of a thoroughly efficient service such nurses ought to be under the immediate control of a hospital-trained matron, and act under the direction of the medical staff. This latter I look upon as most important. To encourage the creation of a number of special district nurses, lady sanitary inspectors, lady health visitors, call them what you like—and I have in mind Huddersfield and other provincial towns and metropolitan municipalities where such appointments have been made—responsible to none but themselves for the advice they give, will be but the making of a superior race of "Gamps" and in the end prove quite as objectionable. As long as these women confine their attentions to carrying out the doctor's orders, they will prove of great usefulness. Emancipated from the only real source of restraint, the doctor, the temptation to give medical advice will soon be yielded to, and with disastrous results to the community. Municipalities would exercise some restraint over these creations, inasmuch as they would be in their pay and subservient to their rules, but there would be no *real* restraining influence in such circumstances, and it is hoped that public health authorities will see to it that the public is properly safeguarded in respect to such appointments.

By such means as I have outlined appropriate nourishment can be brought within reach of the humblest nursling. But there are various difficulties other than the food question to contend against. One of these is to get in touch as quickly as possible with recently delivered women. It is important that the public health authorities should obtain early intimation of the births occurring in their districts. According to the present law births need not be registered for six weeks or more after the event, by which time many infants have succumbed. An alteration in the law is therefore greatly needed.

Huddersfield Council has endeavoured to solve the difficulty by offering a shilling reward to the first person who notifies the birth of a child to the Medical Officer of Health within forty-eight hours of the event. On receipt of the notification the parents are supplied with full instructions as to the feeding, washing, clothing, &c., of infants. Two lady visitors have been appointed to visit the homes of the women to reinforce the printed instructions by a personal interview. Glasgow has copied Huddersfield's methods.

For mothers who have to work away from home the provision of crèches, or day nurseries, under medical supervision, is a necessity. These were first established in France in 1844 by private enterprise; but now they have been taken over by the French municipalities, and children are fed and cared for there at a trifling daily charge, the mother having the right of admission at any time. Not only are these common in France, but they are to be found in the majority of continental cities. There are now some 55 crèches under medical supervision in London, managed by private bodies or individuals, but some of the largest and poorest districts in the Metropolis are unprovided for, or lack sufficient accommodation to meet the great demands made upon them. The need for crèches is now being realised by a few municipalities in London and the country, and powers will be sought in the near future by these corporations to legalise the formation of these very necessary institutions and to financially assist those already formed. The Acton Urban District Council recently applied to Parliament for power to maintain one or more crèches, but the application was refused on the ground that it was a novel proposition from a legislative point of view. A valuable suggestion has been made in regard to these institutions—that they should be made educational centres, and that girls over 14 years might be made to attend occasionally—and the teaching of infant management to such girls should be eligible for aid from the grant for public education.

For mothers who live at home domestic education is all-important. Women who have had no domestic training—who, reared in squalid homes, have spent their lives in factories and shops, who are unacquainted with simple health rules, who have had no experience of marketing, who are ignorant as to the proper storage of food, who are incapable of undertaking simple cooking, who are not thrifty, tidy, cleanly, and resourceful—cannot make good wives or mothers.

Good mothers are necessary for the reduction of infant mortality and for the production of a healthy

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(*a*) "Milk Dispensaries for Children's Hospitals," *Brit. Journ. of Children's Diseases*, March, 1904.

race, and it is on the women that time and money must be spent to bring about the desired result.

How are the women to be approached? There are various channels, such as municipal lady health visitors, municipal classes of instruction, crèches, various religious bodies, the out-patient departments of hospitals, and workhouse nurseries. From a prolonged study of out-patient mothers, I consider that *practical demonstrations* are all-important. I have no faith in set lectures, which are wearying to the majority of educated people, but how unutterably boring to the superficially informed and to those of less acute intellect. The dissemination of knowledge by printed matter is productive of but slight good among the poorer classes. For some years in the annual reports of the Medical Officer of Health for the Urban District of Beckenham I have annually specially called attention to the excessive infantile mortality rate of the district and the plan to prevent it. Steps have been taken by the Press to diffuse this knowledge in the district, but the results have been barren and the high infantile mortality rate shows no abatement. A striking advertisement will readily attract them, but the exercise of a trifling mental effort to abstract information from even carefully prepared literature is rarely undertaken, and not to be expected. In education let us return to the three R's principles associated with a high standard of domestic instruction.

Elementary hygiene, domestic duties, marketing, cooking, thrift, orderly methods, needlework, the care, the feeding, the clothing and domestic hygiene of infants should be practically taught to every schoolgirl. A school was opened in January, 1904, at Harringay, for the instruction of girls between the ages of ten and thirteen in housekeeping, and there is a great need for similar educational establishments in other districts. Not only should girls be taught the domestic virtues in our public schools, but boys should be trained in all the essentials that produce good citizens and good fathers—respect for parents, cultivation of the natural affections, the love of home and country, duty to one's neighbour, personal cleanliness, obedience and decent behaviour, and the leading of well-regulated healthful lives.

Of social evils that make for untold misery in the home and pave the way for infant mortality, betting by the fathers and alcoholism in one or both parents take a prominent place. Carelessness and neglect on the part of the parents and infant guardians are deserving of punishment, and fatalities arising in sequence to these should receive greater attention by the coroners than at present.

Infantile life assurance should either be abolished or more strictly safeguarded; the present system is a premium on infant murder. A law has recently been passed in France which prohibits the insurance of children's lives under 12 years of age, an enactment which could be added with advantage to our statutes.(*a*)

The workhouse nurseries which exist throughout the country and which annually administer to a multitude of infants and their mothers, offer exceptional facilities for the diffusion of knowledge in regard to infantile dietetics and management. From a leading article which appeared in the *British Journal of Children's Diseases*, entitled "The Care of Infants in Workhouses," June, 1904, it would appear that these unique facilities are ignored, and that the average medical officer cares little as to how the young children in the workhouse are fed, and is wholly apathetic as to the effect of his remissness on the national welfare. These nurseries are badly ventilated, cots for infants are condemned, overlying being encouraged thereby, and it would appear that the medical officers very rarely carry out the dietary order of 1900 of the Local Government Board, which includes a special proviso directing that the "medical officer" of the workhouse shall give directions in writing as to the service of food to the infants.

The relationship of proprietary foods to infant mortality is not unimportant. At present these preparations are responsible for the loss of many infant lives and for much child suffering and deformity.

In a recent issue of the *Daily Mail* there was an advertisement issued by a West End firm of chemists—chemists to the King they state—headed "Fine healthy children: An article of the greatest possible interest to mothers, showing how to build up the body, brain, and muscle." The proprietors at great length point out that the future of the child largely depends on the food given during the first few months of life. They go on to state that their food is "the very best food you can give baby." Further, "a booklet will also be sent which is a guide to infant feeding. . . ." Their food, like many others, bulks largely in unaltered starch. This is not an isolated instance, and is taken haphazard from current literature; the advertisement columns of the public Press are full of such appeals to ignorant mothers. Needless to say the opinions of financially interested proprietary food vendors on the subject of what is the very best food you can give baby are not always in harmony with those of the experts—the children specialists—whose knowledge has been laboriously obtained by extensive clinical experience, and has been preceded by prolonged medical training.

Lying-in women, whose maternity is announced in the usual columns of the daily press, are speedily inundated with a variety of articles for the baby by philanthropic tradesmen with an eye to the main chance, the most prominent being proprietary food samples and their accompanying literature. Not content with appeals to an ignorant public by such means, these pushful proprietary food traders bombard the letter-boxes of the profession with pamphlets on infant feeding, and innumerable samples of their wares rattle into these receptacles with surprising regularity; and with unbounded impudence their brazen travellers seek personal interviews with the physician during his consulting hours to push their goods and *inter alia* teach him his profession! That such devices are considered to be worth the outlay incurred is a poor tribute to the knowledge and intelligent interest displayed by the bulk of the medical faculty on the all-important subject of infant feeding.

The advertisement columns of another paper, the *St. James's Gazette*, recently pointed out in large type "How infantile mortality may be controlled." The ingenious solution of the problem is provided by the answer "'Knowing the exact composition of Woodward's Gripe Water, I can with confidence recommend it.' A well-known London physician, name given privately." If I may offer a suggestion, a better solution than that would be knowing the source of the milk supply and its treatment, and the abolition of proprietary foods for young nurslings. There would certainly be fewer infantile stomach-aches. The specious advertisements of the vendors of proprietary foods—and without extensive advertising the commercial life of these preparations would be of short duration—attract the ignorant, and, failing repressive measures by the Legislature, means should be adopted to instruct parents as to the harmfulness of these products when given to very young nurslings.

A French law forbids anyone under the threat of heavy penalties, from giving infants under one year of age any form of solid food unless ordered in writing to do so by a qualified doctor. Some such law in this country would prove of great service and would restrain the attention of the ignorant and foolish who thrust into the mouths of infants to their great detriment such articles as carrots, gin, bacon, beer, pudding, tea, cakes, and meat.

Another factor in infantile mortality is not infrequently the extreme poverty of the parents; the expenditure for milk in some instances is not more than one penny a day, and I have known it to be as low as half that amount. An infant, of course, cannot thrive on such a meagre allowance, and properly administered *outdoor* relief should in such cases be

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(*a*) "Child Life Insurance," *Brit. Journ. of Children's Diseases*, February, 1905.

given to the mother and should carry with it the knowledge that the doctor can be consulted should the child fall ill.

Medical students should be taught children's diseases and infantile disorders at the children's hospitals and undergo an examination therein before obtaining their diplomas. They should not be allowed, as at present, to practise the medical prefession without having made themselves thoroughly acquainted with the care and treatment of infants. That our future medical practitioners should be so educated that they will be in a position to give sound medical advice to the public on infantile and childish ailments is most important.

It follows, therefore, that the reduction of the present high infantile mortality rate is a complex social problem, and demands the adoption of a variety of remedial measures and the hearty co-operation of all classes of the community to bring about a successful result.

The perils at man's hand that beset the infant to rob it of life and health from its advent into the world are numerous and deadly.

Infant life and infant health are national assets of far-reaching importance—how important to England in the future no man can foresee. Has not the time arrived for the Legislature to prescribe appropriate remedies to safeguard its future citizens, wealth-producers, and protectors?

OCULAR THERAPEUTICS. (a)

By SYDNEY STEPHENSON, M.B., F.R.C.S.E.

(Continued from Page 138.)

Lecture II.

2.—Mydriatics.

We may first usefully distinguish between "mydriatics"—that is, agents capable of causing dilatation of the pupil—and "cycloplegics"—that is, agents capable of paralysing the ciliary muscle and consequently the function of accommodation. Every cycloplegic with which I am acquainted is also a mydriatic, but the converse proposition, as we shall see immediately, is not true, or is true in a restricted sense only.

The two groups, cycloplegics and mydriatics, serve different purposes. Broadly speaking, the first-named are employed before estimating refraction, whereas the last-named are used to dilate the pupil in disease or to facilitate full ophthalmoscopic examination of the media or the fundus of the eye.

The agents that act mainly upon the musculature of the iris and affect the ciliary muscle scarcely at all are three in number—cocaine, euphthalmine, and mydrine. On the other hand, those that paralyse the ciliary muscle, together with the sphincter of the iris, are four in number—atropine, homatropine, eumydrine, and the methylbromate of atropine. I leave out of account several other agents that act in the one way or the other, such as scopolamine, duboisine, daturine, hyoscine, atroscine, picramine, and hygrine, because there is still some doubt with regard to their chemical composition, and few of them, except perhaps scopolamine, seem likely to render any great practical help in eye work.

Let us suppose that we desire to dilate the pupil, for the purpose of obtaining a satisfactory view of the fundus oculi with the ophthalmoscope. Atropine is about the last drug that a progressive ophthalmic surgeon would employ, because his experience tells him that the resulting disturbance in sight would be considerable, and would persist for several days. On the contrary, he would use a mydriatic pure and simple. Until the last few years cocaine was practically the only agent at our command which would dilate the pupil moderately and yet produce no considerable or lasting effect upon the function of accommodation. Even that agent now and then played us false, and caused an uncomfortable dimness of sight. Modern pharmacy, however, has again stepped in, and supplied us with *Euphthalmine*, a mandelic acid derivative, the hydrochloride salt of which appears in the form of a white crystalline powder, soluble in cold water. It may be used to dilate the pupil simply as a 3 per cent. to 5 per cent. aqueous solution, although its action in that direction is heightened and hastened by the addition of cocaine hydrochloride, 2 per cent. The mixture, moreover, is somewhat cheaper, since it allows the lower percentage of euphthalmine (a very costly drug) to be employed. A few drops of this combination placed in the conjunctival sac will cause the pupil to dilate in about thirty minutes, with a minimal effect upon the function of accommodation. The dilatation passes away in a variable time, which averages about four hours, a process that may be quickened by applying a drop of physostigmine, 0·5 per cent., to the eye after the examination is completed. It will be gathered from what has been said that euphthalmine, alone or mixed with cocaine, is the agent to employ when it is desired to dilate the pupil for purposes of ophthalmoscopic examination without causing anything beyond trifling discomfort to the patient.

Mydrine is a compound of ephedrine and homatropine hydrochlorides, and when used as a 10 per cent. solution acts in the same way as euphthalmine. It is, however, a mixture, and, so far as I know, presents no single advantage over the last-named agent. The pupil, moreover, retains its action after mydrine has been used, and the amount of dilatation is less than after euphthalmine.

The important point to bear in mind is that after the employment of either euphthalmine or mydrine patients may be assured that they will be able to transact their business as usual, which is certainly not the case after atropine has been dropped into the eye. Mydrine solutions, it may be added, are very stable.

With regard to atropine, I have no new facts to bring under your notice, except perhaps the claim lately made by Dr. T. K. Hamilton (*Ophthalmoscope*, May, 1905) that the annoying conjunctivitis and dermatitis sometimes produced by it may be obviated by employing a solution of chloretone as the vehicle instead of ordinary distilled water, and of Dr. W. G. Sym (*ibid.*, April, 1905) that the same end may be attained by using the alkaloid dissolved not in water at all but in pure olive oil.

Eumydrine.—This new mydriatic, which occurs as a white powder, readily soluble in water, has been investigated by Goldberg (*Heilkunde*, 1903) and by Lindenmeyer (*Berl. Klin. Woch.*, November 23rd, 1903). According to the former observer, a 1 per cent. solution acts more promptly than atropine (1 : 1,000), and its effects pass away more rapidly. No injurious results have been noted. Eumydrine, indeed, is stated to be fifty times less poisonous as regards the central nervous system than atropine, from which, by the way, it is obtained. Eumydrine acts as a trustworthy cycloplegic. Lindenmeyer found the new agent to be of service in such inflammations of the eye as would ordinarily be treated with atropine.

Speaking for myself, I have employed eumydrine in a solution containing two grains to the ounce of distilled water, and have satisfied myself that it is a speedy, painless, and trustworthy mydriatic. Complete cycloplegia follows its use. It differs in two important points from atropine. First, the paralysis of accommodation induced by eumydrine instead of lasting for upwards of a week as with atropine, usually passes away in the course of two or three days. Secondly, its action both upon the pupil and the ciliary muscle may be neutralised in half an hour or so by means of a weak solution of physostigmine (0·5 per cent.). This is not possible after atropine has been employed.

In the course of my experiments with eumydrine I have been impressed by one point, namely, that it is usually an excellent substitute for atropine when appearances of local intolerance to that remedy are present. In order to bear out this somewhat important practical observation, I may briefly quote one or two illustrative cases. (1) Jessie H——, æt. 12, was ordered atropine (grs. 2) on July 4th, 1904, as a preliminary to estimating a considerable error of refraction. After four applications of the atropine drops the child's face became red. When seen on July 8th, the eyelids were puffy, and, like the neighbouring parts, red and angry-looking. The skin of the eyelids, when grasped between the fingers, conveyed a parchmentous feeling. There was dried muco-purulent discharge about the eyelids. A solution of eumydrine, grs. 2 to the ounce, was substituted for the atropine. The new drops were used twice a day until July 25th, without setting up the least irritation. (2) Maria M——, æt. 60, was ordered atropine drops (gr. 1 to the ounce) on August 8th, 1904, on account of choroiditis accompanying high myopia. A fortnight later (August 22nd) she presented herself suffering from extensive atropine irritation of the eyelids and neighbouring skin. The affected skin was parchmentous, dry, shiny, and red. The patient complained bitterly about the drops that had been given to her. Eumydrine (grs. 2) was substituted for the atropine. A week later the patient was free from all symptoms of irritation, and the eumydrine has produced no discomfort at all. (3) Emily G——, æt. 18, ordered to both eyes atropine drops, grs. 4 to the ounce, on December 12th, 1904. After one application, the skin on the left side of the face, as far as the level of the nostril, became red, swollen, and tender, and "seemed tight." Furthermore, she was only just able to open the eye. Eumydrine, grs. 4 to the ounce, acted well upon the pupils, and produced no irritation, though used three times a day for three days. (4) The effect was not so happy in the fourth case, that of a young woman, who was affected with bilateral interstitial keratitis, the result of inherited syphilis. In that case the usual type of irritation was induced by atropine, duboisine, hyoscyamine, and by eumydrine. It is, however, the only instance of the kind I have met with.

(a) Lectures delivered June 1905, at the Polyclinic, London.

The slight poisonous qualities of eumydrine lead me to think that it may prove useful in children for paralysing the accommodation before estimating the static refraction of the eye, and that in certain cases where the long-continued employment of a mydriatic is desirable—for example, in squint, interstitial keratitis, and so forth—it will be found to offer some advantages over atropine.

Methylbromate of Atropine.—This product occurs as white crystals freely soluble in water. It is, like eumydrine, a good substitute for atropine. Its action depends upon its strength. A 1 per cent. solution produces rapid dilatation of the pupil accompanied by cycloplegia. But combined with 1 per cent. cocaine it dilates the pupil without having much effect upon accommodation.

General Conclusions with regard to Mydriatics.—In certain inflammations of the eye, as iritis and iridocyclitis, no mydriatic, except perhaps eumydrine, can, according to our present knowledge, equal atropine, employed either as the sulphate, grs. 2 to grs. 4 to the ounce of distilled water, or as a solution of the alkaloid of the same strength in olive or castor or sesame oil. To dilate the pupil in suspected iritis for the purpose of ascertaining whether adhesions exist, it is better to select some agent, as the methylbromate of atropine, the effects of which pass off rather quickly. For estimating refraction in children atropine sulphate (grs. 2 to grs. 4) is at present in almost universal use, although it may well be replaced by eumydrine, on account of the slight toxic properties of the latter. A similar remark is equally applicable to cases where the long-continued employment of a mydriatic is called for. For estimating refraction in adults, atropine, in general, should be avoided, and recourse be had to homatropine and cocaine, each 2 per cent., to eumydrine, 1 per cent., or to atropine methylbromate and cocaine, each 2 per cent. To enlarge the pupil for ophthalmoscopic examination, mydrine, 10 per cent., or, better, a mixture of euphthalmine and cocaine, of each 2 per cent., should be adopted. Atropine is absolutely contra-indicated under the circumstances. Remember, finally, that atropine is not the panacea it is sometimes believed to be for almost every inflammatory affection of the eye. When in doubt do *not* prescribe that drug. No mydriatic agent whatever, no matter how quickly its effects pass away, should ever be used in grown-up persons until tension has been estimated with the finger and glaucomatous cupping of the optic disc has been excluded by a glance with the ophthalmoscope.

3.—Myotics.

In physostigmine and pilocarpine respectively, we have two agents capable of contracting the pupil, the former energetically and the latter in a milder way. The salicylate of physostigmine has been recommended by Dr. T. K. Hamilton (*Ophthalmoscope*, May, 1905) as a particularly suitable salt for prolonged use in chronic glaucoma. A substance named isophysostigmine, another alkaloid of the Calabar bean, has recently been investigated by Ogiu, a Japanese oculist (*Die Therapie der Gegenwart*, November, 1904). That surgeon found that the drug acted more quickly upon the pupil, and with greater energy, and for a longer period than physostigmine. These claims, if substantiated are likely to lead to the general employment of isophysostigmine. Another comparatively new myotic, Arecoline, has fallen under my personal notice. It is one of the several alkaloids of the betel nut, and used as the 1 per cent. solution of the hydrobromide salt, has rendered service in glaucoma. By several observers, Mr. Richardson Cross, of Bristol, among the number, it is considered to be the best myotic for general use. But according to the younger Galezowski (*Recueil d'Ophthal.* XXV., 1903, p. 112) even a half per cent. solution now and then gives rise to irritation of the conjunctiva.

4.—Anæsthetics and Analgesics.

Anæsthetics may be defined as agents capable of rendering the eye insensitive to the pain of surgical operations, while analgesics are agents capable of obtunding any pain that may exist. The distinction between the two classes comes out very clearly in eye work, when we compare the action of two such medicaments as cocaine and dionine. The former, when dropped into the eye, renders the superficial parts insensitive, but has no definite influence upon the deep-seated pains of, say, iritis and glaucoma, whereas the latter deadens such pains without at the same time rendering the parts insensitive.

The anæsthetic for choice is still cocaine hydrochloride, as a 2 per cent. watery solution. In actual practice, however, it still leaves something to be desired, and to some extent, especially in America, it has been replaced by a 1 per cent. solution of the hydrochloride of holocaine. Holocaine, it is true, has advantages over cocaine. For example, it is a pure local anæsthetic, without action of any kind, sort, or description upon the pupil, accommodation, tension, or corneal epithelium. For the relief of deep-seated ocular pain, as Hinshelwood has pointed out (*British Medical Association*, 1898) it is greatly superior to cocaine. My personal experience has convinced me that it has bactericidal powers, and, further, that it is better absorbed by a reddened eye than is cocaine. Its only drawback is that owing to its toxic properties it cannot safely be injected into the lachrymal passages or beneath the conjunctiva or the skin.

Dr. Carl Koller, who brought cocaine under the notice of the profession twenty-one years ago, has lately made a practical suggestion with regard to its use in cataract and other operations upon the eye (*Ophthalmoscope*, September, 1904). One or two minutes after placing a few drops of cocaine in the conjunctival sac, he injects 2-3 drops of a 5 per cent. solution beneath the ocular conjunctiva at the spot where he intends later to apply the fixation forceps. Five minutes afterwards, operations upon the eyeball, even such as involve the iris, can be performed without pain. I cannot help thinking Dr. Koller's suggestion has not yet had the attention paid to it that it deserves.

Eucaine lactate is a white powder, readily soluble in water. Its sole action is to induce local anæsthesia. For use in eye work, Langaard (*Therapeutische Monatshefte*, August, 1904), who regards the new agent as a substitute for cocaine, recommends a 2 per cent. or 3 per cent. solution, combined, if necessary, with adrenaline.

After a tolerably extensive trial of a 2 per cent. watery solution of eucaine lactate, I have reached conclusions regarding its action upon the eye that may be summarised as follows: the agent has no action whatever upon the pupil, ciliary muscle, or epithelium of the cornea. It produces neither redness nor anæmia of the superficial parts of the eyeball, nor does it give rise, as cocaine often does, to retraction of the upper eyelids. Its effect upon tension is nil. It sets up about the same amount of smarting when placed in the eye as cocaine—certainly not more, as Ellis (*California State Journal of Medicine*, Vol. III., No. 5) has stated. Thus, twelve adult patients æt. 27 to 77, had a drop of 2 per cent. cocaine placed in one eye and of 2 per cent. eucaine lactate in the other, and the discomfort was greater in the first eye in two instances, in the second eye in five instances, and was equal in the two eyes in five instances. Finally, local anæsthesia of a satisfactory nature is quickly induced, three minutes sufficing for the purpose, according to the mean of twenty experiments. In some cases of pain from irido-cyclitis and other causes, the discomfort was lulled for an hour or more by a few drops of eucaine lactate. In short, my personal experience confirms Langaard's claim that in eucaine lactate we have an agent whose sole action is to produce local anæsthesia. Additional good points about the new remedy are its ready solubility in water, its comparative cheapness, its relative non-toxicity, and the fact that it undergoes no appreciable change when boiled, so that it may be kept sterile for an indefinite period. Further trials should be made with this interesting product, which possesses, as we have seen, some decided advantages over cocaine.

A good deal of attention, especially in France, has lately been paid to another local anæsthetic, the discovery of Fourneau, called Stovaine, the hydrochloride of amyleine B.P. It occurs in small white flakes, is extremely soluble in water, and its chemical reactions are almost identical with those of cocaine. Its solutions are not altered by boiling until a temperature of 120° C. has been reached, clearly an advantage from a practical point of view. Coakley (*Medical News*, April 15th, 1905) finds that the aqueous solution can be boiled for an hour without undergoing the least change, and that the stovaine can then be recovered intact by simple evaporation. The toxicity of stovaine is equal to one-half or one-third, that of cocaine being represented by one.

My experiments were made with a 4 per cent. watery solution of stovaine hydrochloride. I have found that it is a good local anæsthetic, and I have now performed a fair number of operations under its influence. Its action is that of an almost pure local anæsthetic, although retraction of the upper eyelid and slight dilatation of the pupil may follow its application, as pointed out by Fromaget and Dion and myself (*Ophthalmoscope*, November, 1904). Accommodation, however, is not affected. In a 1 per cent. or 2 per cent. solution it is very suitable for injection beneath the conjunctiva before operating for squint, removal of a piece of iris, or cataract. In brief, I conclude that in stovaine we have a trustworthy and relatively non-toxic local anæsthetic, and one capable of ready sterilisation by boiling, and as such I commend this latest product of synthetic chemistry to your notice. It may be combined with cocaine or adrenaline, and there are some reasons for thinking that the admixture acts better than the individual drug. In the treatment of disease, stovaine may be combined with other remedies, as ammoniated mercury or yellow oxide of mercury, in an ointment. But in that event the general rule applies, namely, that the alkaloid itself must be used and not a salt. A similar remark applies to oily menstrua.

Yohimbine, an alkaloid from Yamabehoa bark, has enjoyed a reputation for a few years as an aphrodisiac. Magnani, Salomonsohn, Loewy, and Muller have employed a 1 per cent. solution as an ocular anæsthetic. Claiborne and Coburn (*Medical News*, July 9th, 1904), who used a 2 per cent. solution, concluded as the result of their experimets that yohimbine, in addition to being a local anæsthetic, caused smarting and suffusion of the eye, moderate dilatation of the pupil, and slight blurring of sight, due not to paresis of accommodation but to spherical aberration. The high price of yohimbine, together with the fact that it is not a local anæsthetic, pure and simple, will militate against anything like its general employment.

An analgesic of practical importance has lately been introduced in the shape of Dionine, the hydrochloride of ethyl-morphine, a white powder, soluble in water, and employed in eye work as a 1 per cent. to 10 per cent. solution. It has little if any action on superficial structures, as conjunctiva and cornea, thus differing markedly from cocaine. When dropped into the eye, especially of children and unhealthy adults, it not infrequently gives rise to pain, chemosis, and swelling of the eyelids, and, by finding its way into the nasal passages, to sneezing—"ophthalmologic fireworks," is the expression applied by Dr. A. B. Hale (*Ophthalmic Record*, December, 1903) to describe these untoward effects of dionine. After use for some days (two or three usually) reaction of the kind described either fails to appear altogether or manifests itself in a trivial way.

The changes alluded to, which are more striking than dangerous, are ascribed to an inundation by lymph of the tissues of the eye, and this lymphagogue property of dionine has been utilised for the removal of inflammatory products, such as opacities of the cornea and the lenticular remains after cataract operations. Bulson (*Ophthalmic Record*, August, 1904) writing on this subject, says: "In fact, the remarkable results secured by dionine in clearing the pupillary space following cataract extraction has led to the belief that, with the more or less general employment of dionine after cataract extractions secondary operations will be greatly lessened in number." Time alone can show whether this claim can stand! Dionine is useful in interstitial keratitis in hastening the absorption of corneal deposits late in the history of the disease. In this condition I have myself obtained excellent results. In such cases there is, as usual, a right and a wrong way of using dionine. The right way is to drop a 5 per cent. solution into the eye three or four times a day for a couple of days, and to repeat the process after waiting some three days. In children I have cured many septic ulcers of the cornea, associated with pus in the anterior chamber, by simply dropping dionine into the affected eye.

Darier has pointed to another and even more practical use of the new product—namely, the induction of analgesia lasting for several hours in some of the more painful affections of the eyeball, as episcleritis, hypopyon-keratitis, irido-cyclitis, and glaucoma. This action is most useful, since agonising pain may often be calmed by the simple expedient of applying to the eye a few drops of a 5 per cent. solution of dionine. In acute iritis, especially when of "rheumatic" origin, I often prescribe: Atropine sulphate, grs. 2; dionine, grs. 5; water ½ oz.; the liquid to be used two to six times a day, according to circumstances. Dionine may also be combined with physostigmine or pilocarpine in the medical treatment of glaucoma. A useful combination is—physostigmine sulphatis, gr. ¼; dionine, grs. 5; water, drachms 4.

Blanco (*Archivos de Oftalmologia*, August, 1904) has successfully treated two cases of intra-ocular hæmorrhage by means of the subconjunctival injection of dionine.

As a symptomatic rather than as a curative agent, dionine is well worth the earnest attention of practising physicians. In my experience, it is a most efficient analgesic. For the relief of deep ocular pain the 5 per cent. solution should be employed every four to six hours, according to the particular circumstances of the case.

One other analgesic remains to be mentioned, viz., Acoine, the employment of which for rendering subconjunctival injections painless or almost painless has been alluded to earlier in these lectures.

General Conclusions as to Anæsthetics and Analgesics.—To my thinking, the ideal anæsthetic or analgesic should fulfil three requirements: first, it should exert simply an anæsthetic or analgesic action, as the case may be; secondly, it should not irritate the eye; and, thirdly, it should be readily soluble in water, economical in price, and non-toxic in use. Bearing these various points in mind, it will be found that the best agents to employ preliminary to an operation on the eye, named in their order of merit, are holocaine, 1 per cent.; eucaine lactate, 2 per cent; stovaine, 4 per cent.; and cocaine, 2 per cent. For injection, holocaine must be carefully eschewed, and the preference be given to stovaine, 1 per cent.; eucaine lactate, 1 per cent. or 2 per cent.; or cocaine, 1 per cent. or 2 per cent. To obtund deep-seated pain in the eye, irrespective of its cause, we use dionine, 5 per cent.; combined in iritis with atropine and in glaucoma with physostigmine or pilocarpine. To render subconjunctival medication as little painful as possible, acoine, 1 per cent. or 2 per cent. is the agent *par excellence.*

AN EFFECTIVE

ARMY MEDICAL RESERVE

FOR THE

AUXILIARY AND REGULAR FORCES. (*a*)

By Surgeon-Colonel P. B. GILES, F.R.C.S., V.D.,

Staff Medical Officer, 30th Field Army Brigade, and of the Volunteer Ambulance School of Instruction.

For the best interests of the nation the relationship between the regular and auxiliary medical services should be as intimate as can be between co-ordinate bodies. The old idea that the regular medical service (R.A.M.C.) should only be sufficient to administer to a mixed force of 80,000 troops was rudely disillusioned at the commencement of the late war; this fallacy was exploded, and it is certain, however apathetic the country may be at the present moment, should another big war occur with similar unpreparedness, that the nation would demand a day of reckoning, and that a severe one. The easiest, and in the end the cheapest, policy is to prepare for war during the piping days of peace. It is silly after a war has broken out inquiring, Where is the medical reserve when, as a fact, even in peace, the field strength of the R.A.M.C. is deficient? There is only one way to create a potential and effective Army Medical Reserve, and that is to utilise the auxiliary medical services. The way to effect this is simple, the cost comparatively little. Take the cost of those who die, or are disabled from preventable causes during any, or all, of our campaigns, as compared with that which will follow the present admirable system adopted by the Japanese.

The auxiliary medical services should be developed so that its personnel could supply all the duties of the R.A.M.C. as high as that of principal medical officer, so that in the event of a war in which all the officers of the R.A.M.C. were required out of England, there should be officers of the auxiliary medical service qualified to perform their duties. This may seem a big order, yet comparatively little extra training would accomplish it. The method is simple. First, the auxiliary medical service, as I have urged for years, must be made a reality and not merely a force on paper. That this is a possibility the practical results of the labours of the late D.A.D.-G., Colonel Wilson testify; for whilst engaged in the organisation and supply of the R.A.M.C. during the late war, he was able to develop a practical scheme for volunteer bearer companies. If all units of the auxiliary forces were brigaded, and proper brigade medical companies were recruited and welded into a concrete auxiliary service (R.A.M.C.V.) the chief difficulty would be overcome. By brigade medical unit I mean a unit capable of performing the duties of a field hospital, a bearer company, and the sanitary or preventive disease work of a brigade, such as I have advocated in papers read at the meetings of the British Medical Association, and such as I have practically used for years in brigade camps. In such units officers and men should be allowed when they changed their localities to be transferred. Secondly, the regimental stretcher-bearers should be a reality, and not, as they now so very frequently are, a force existing, or not, upon the caprice of the officer commanding. It should be a *sine quâ non* for obtaining the annual grant that a complete section holding A.F. 596 parade under the medical officer.

All medical officers of units should when gazetted to their unit pass automatically into the R.A.M.C.V. because:—First, during the late war great numbers of volunteer medical officers were refused attachment for service to the R.A.M.C. because it was stated the officer commanding their units had control of them. Secondly, by so doing all but one medical officer in each unit would be at the disposal of the surgeon medical officer for duty other than regimental. Thirdly, because then the most suitable could be utilised with his unit; it is ludicrous to see a Surgeon-Lieutenant Colonel doing regimental duties in the field when his Surgeon-Lieutenant is on duty in hospital. Fourthly, because this system would permit of free exchange in those cases in which the medical officer changed his residence.

This plan would produce a concrete body co-ordinate with the R.A.M.C. which proper training would enable to take over most of the duties of the R.A.M.C. when required at a time of national danger. In the time of peace there should be a volunteer medical officer of the rank of Colonel at the Medical Department of the War Office. He should be the Director-General's adviser on volunteer medical subjects, and generally supervise the service. In each command there should be a volunteer Lieutenant-Colonel, who should similarly represent his service, and should inspect and report upon the medical efficiency and requirements of the R.A.M.C. volunteers and units, and should appoint Boards to examine for A.F.E. 596 and A.F.E. 624.

As at present, all volunteer medical officers should be examined for their A.F.E. 564, but in addition to those who by attending at Aldershot, who, if successful, receive an allowance for attending, and who up to the present can be counted upon the fingers of one's hands, similar daily allowances should be granted to those officers who attend (and pass) at the Volunteer Ambulance

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(*a*) Paper read at the Royal Institute of Public Health, London Congress, July, 1905.

School of Instruction, which has taught and passed 700.

Later, when the volunteer medical officer has passed and obtained field rank, then, if he desires further advancement, it should be compulsory for him to attend for a month at Aldershot, Netley, &c. If my ideas, or modifications of them, were adopted, there would be at once—fairly trained on the lines of the R.A.M.C. and accustomed to discipline—a large body of men sufficient to form a real Army Medical Reserve. In time of war this Army Medical Reserve could be fed by civilian trained men, such as St. John's Ambulance, who would come having had elementary instruction in their future duties. There is no doubt that the priority given to firemen and St. John's Ambulance men during the late war was prejudicial to the best interests of the volunteer medical service. The idea that civilian aid is to supplement the regular medical forces in war is wrong, chiefly because it is neither so well trained nor disciplined, and has this anomaly, that the military authorities are more or less hampered by civilian bodies, who do not hesitate to employ private influence to obtain the better treatment of their respective organisations.

Clinical Records.

CASE OF NEURITIS OF THE LEFT ULNAR NERVE FOLLOWING AN ATTACK OF PNEUMONIA, WITH DRY PLEURISY ON THE SAME SIDE. (a)

By Major Emile Rouyer, M.D.,
Of the French Army Medical Service.

The occurrence of paralysis and neuritis following pneumonia has long been recognised, and the subject was fully dealt with in the graduation theses of Boulloche and Jonakieff. In the experience of these authors the cases may be divided into two distinct categories, according to the date of the appearance of the paralysis, which is sometimes early in onset, occurring at the very commencement of the attack or during the period of maintenance of the disease; in others, the paralysis supervenes during defervescence or convalescence.

The case I am about to relate belongs to the latter category. It is unfortunately incomplete owing to the fact that the patient was treated in a small garrison town where no means were available to investigate the various electrical reactions. He was one of five children, all alive and in good health. His mother died of inflammation of the lungs and his father from a gastric (?) affection. He had never been ill before, but stated that as a child he was very liable to headache, the attacks ceasing at the age of puberty. He was left-handed. He joined the army in November, 1899, and was passed as of sound constitution and lymphatic temperament. He did his first few months' service without any difficulty, but in July, 1900, he was admitted to hospital suffering from a moderate attack of left lobar pneumonia, after which for several months we could hear pleural friction. This was treated by counter-irritation, and in December, 1900, he appeared to be quite well.

On February 22nd, 1901, he came complaining of tingling in the fourth and fifth fingers of the left hand with vague pain in the left shoulder. It was noted that the ring and little finger were semi-flexed, though they could be easily extended. In the course of the next few days the flexion became more pronounced, and there was resistance on trying to straighten the fingers. At the same time the tingling was associated with lancinating pain from the hand to the shoulder. On March 1st, the "ulnar claw" was distinctly present. He was transported to the military hospital at Belfort, where he underwent a course of treatment by electricity and left much improved. He was given two months' holiday.

On his return to the regiment on June 13th, he was in the same state. The ulnar claw was still well marked. The first phalanx of the fourth and fifth fingers was in complete extension, and the two last phalanges in complete flexion. All attempts to straighten the fingers failed and caused pain. At the same time the thumb was drawn back by the extensor, and could not be opposed to the other fingers by reason of the paresis of its adductor muscle.

The sensory troubles were purely subjective. He still complained of tingling in the left arm, and on the slightest exertion he experienced sharp pain from the shoulder to the tips of the fingers. No hyperæsthesia, no anæsthesia, nor delay in the transmission of sensation. The temperature of the left hand was lower than the other, and the skin over the tips of the fingers was livid. No trophic disturbance, and there was no obvious atrophy of the arm, but we must bear in mind that the patient is left-handed.

I left the garrison soon after, but I am informed that the neuritis has persisted unchanged in that there had been no change for the worse. I may add that this patient, who was under close observation for several months, never presented any sign of pulmonary tuberculosis, his general health remained good, and he had gained in weight since his return to the regiment.

Observations of ulnar neuritis following pneumonia are not often met with in military hospitals where pneumonia usually assumes a frank aspect. Busquet, in his work on the subject, does not mention pneumonia as one of the affections capable of leaving peripheral nervous lesions behind it. After all, there is nothing surprising that the toxins of the pneumococcus should act like those of Eberth-Löffler, or the streptococcus; indeed, it may be, in the case under consideration, that some importance should be attached to the pleural friction noted during convalescence from the attack of pneumonia. I may add that Dejérine, in his article in Bouchard's treatise on pathology, mentions a case of neuritis of the ulnar nerve following influenza, and refers to the same lesion as having been observed by Nothnagel, Bernhardt, Pitres, and Vaillard after typhoid fever.

British Medical Association.

Seventy-third Annual Meeting, July 24th to 28th.

[From our Special Correspondent.]

THE SURGICAL SECTION.

The first day's meeting of the Surgical Section was for the most part devoted to a discussion on the "Surgical Treatment of Non-Malignant Diseases of the Stomach." This was opened by Mr. B. G. A. Moynihan. He considered first the subject of acute perforating ulcer. Excision of the ulcer at the time of operation he held to be unnecessary, the necessity for lavage of the peritoneum and drainage he looked upon as determined by the time which had elapsed since the perforation. He performed gastro-enterostomy when the ulcer was near the pylorus and the infolding involved some narrowing of the latter, and he advised washing out of the stomach with the stomach tube. In cases of serious hæmorrhage from the stomach he had found gastro-enterostomy the safest and surest method of arrest. This he explained on the ground that when the stomach is emptied and collapsed the hæmorrhage tends to cease spontaneously. In chronic ulcer of the stomach he considered that the question of operation should be considered early, the results now obtained by operation showed that for this condition the treatment should be surgical and not medical; the mortality was less, the results were better, and the risks from lethal complications were avoided. Gastro-enterostomy was the operation he preferred, and also the same procedure for hour-glass stomach; for the latter condition, however, other methods were sometimes necessary.

(a) *Bulletin Medical*, March, 1905.

Professor Saundby expressed the opinion that stomach conditions were pre-eminently those in which the co-operation of the medical and surgical elements in consultation were desirable. Hæmorrhage from gastric ulcer he considered a condition that rarely called for operation; he had never had a fatal case. A large proportion of cases of gastric ulcer were curable by medical means, although where the ulcer heals and constriction or adhesions follow, the indication for surgical assistance could not be disputed. He dissented from the view that all cases of chronic inveterate dyspepsia should be surgically explored. Many of such cases were of nervous origin with atonic dilatation, and were made worse by operation.

Important contributions to the discussion were those by Professor Hartmann, of Paris, and Dr. Finney, of Baltimore. The former considered gastro-enterostomy generally the best operation in the treatment of non-malignant stomach diseases; the mortality of his last 47 cases had been 6 per cent. He thought this would be lower if French physicians would advise the operation in time, which was unfortunately not the case. The complications he had had were chiefly pulmonary, and he considered the care of the mouth during the days previous to operation a matter of importance. In pyloric stenosis and moderate hæmorrhage recurring many times patients were cured by gastro-enterostomy, the remote results were also good in intractable ulcers not cured by medical treatment. He did not agree with those who held that excessive hæmatemesis needs an operation. The operative mortality of such cases was high, and the cure by medical means frequent. He, however, operated in all cases of small and repeated hæmatemesis.

Dr. Finney first described the operation of pyloroplasty of which he published a description in 1902. He now performed this operation in preference to gastro-enterostomy. In 25 cases of his own he had had a mortality of three. He had collected 112 cases from the literature with a mortality of 8·9 per cent.

Mr. Mansell Moullin, in operating for chronic ulcer, always excised whenever possible, in addition to performing gastro-enterostomy. He thought that the proportion of cases of chronic ulcer which formed the basis of carcinoma was usually under-estimated.

Mr. F. S. Eve thought excision of a chronic ulcer was unnecessary and usually impracticable. He attached importance to a thorough examination of the interior of the stomach in all cases. He performed posterior gastro-enterostomy. Pyloroplasty he had only performed once, and the pyloric constriction had recurred later.

Mr. Rutherford Morison did not think that gastro-enterostomy was likely to maintain its present position. He preferred pyloroplasty whenever possible.

The other speakers dwelt chiefly on the advisability of extending the sphere of surgical treatment in non-malignant stomach diseases. Posterior gastro-enterostomy was preferred to the anterior operation by the majority, and most also appeared to agree with Mr. Moynihan when he said that pyloroplasty, that is to say, the Heinecke-Mikulicz operation, was dead. Mr. Moynihan held, however, that the Finney operation was a good one, and that the choice of the future lay between this and posterior gastro-enterostomy.

On Thursday, July 27th, a discussion on the "Surgical Treatment of Malignant Disease of the Rectum" was introduced by Sir Robert Ball. He pointed out how trivial were the symptoms in the early stages of the disease in many cases, and emphasised the necessity for digital examination in all rectal complaints. When the colon could be properly emptied before operation, he considered colotomy unnecessary and objectionable. Perineal excision he adopted only when the anal canal was involved. In some cases he performed partial excisions, that is, in growths involving only part of the circumference of the bowel. In the sacral operation he removed the coccyx along with part of the fifth sacral vertebra. He thought that the method of bringing down the bowel and suturing to the natural anal canal denuded of its mucous membrane was the one which promised the best results. In two of his own cases a small portion of the gut sloughed in two instances, but an excellent result was eventually obtained. In three cases which had been operated on by the abdominal route he had been able to finish the operation in the same way. The abdominal route he considered offered several important advantages in estimating the extent of the disease, arresting hæmorrhage and clearing out lymph glands, and he thought that many cases which had been treated by trans-sacral excision would have given a better result by this method.

Mr. Swinford Edwards had found the aero-proctoscope of value in diagnosis. He favoured preliminary colotomy when the peritoneal cavity was likely to be opened, and when there was likely to be a large fæcal accumulation. Where preliminary colotomy had not been done he always endeavoured to avoid opening the peritoneal cavity. He performed partial excision in some cases when the disease was limited to the posterior or postero-lateral wall.

Professor Hartmann said that he had operated on 64 cases of rectal cancer since 1896, 43 by palliative operation. In 21 cases treated radically he had had one death. In cancers above the anus he brought the rectum down through incisions surrounding the anus, and continuing on to the left side of the coccyx, which he removed. After freeing the rectum and opening the peritoneum, the margin of the bowel above the growth was brought down and sutured to the skin. He had obtained in this way twelve recoveries in twelve cases; three had had recurrence after six, seven, and eight months.

Mr. Stanmore Bishop said that he had given up all operations from the perinæum alone. In the sacral operation he preferred end-to-end union of the bowel.

Mr. T. G. Atkins thought that in the future many more cases would be operated on by the abdominal route. In operating by the sacral route he finished the operation by inserting a Paul's tube into the proximal end.

Mr. Sinclair White showed a specimen in which a rectal diverticulum was attached in the neighbourhood of a cancerous mass. He avoided colostomy in elderly patients if the disease was quite recent, but resorted to it in others. He had had one death from peritoneal infection in a case of removal by the vagina. Of 26 cases five had died from the operation; nine of those who had recovered had been operated on more than three years ago, four of these were free from recurrence three years after operation. He had decided to give up the sacral route for the abdominal.

Mr. E. Deanesly always removed the whole of the rectum saving the anal canal, wherever possible, and brought down the sigmoid to the denuded anus.

Mr. Mitchell said that he was in the habit of commencing operation by separating the anal mucous membrane and ligaturing the tubular process thus formed to prevent fæcal contamination.

Mr. C. Ryall thought that an examination under an anæsthetic should always be made before deciding that a growth was too fixed for removal. During operation the greatest care should be taken not to tear the growth or cancerous material might be implanted in the wound.

Mr. Jackson-Clarke said that in high rectal cancer complete removal of the rectum through the abdomen and the bringing of the sigmoid flexure to the anus was now giving better results than the sacral operation.

The majority of the speakers who took part in the discussion held that a preliminary colostomy was unnecessary. No series of statistics comparing the abdominal and sacral routes was put forward, but it was a general opinion that the abdominal route would gain in favour in the future. The method of Monlonguet of bringing the upper end of the bowel down to the anal canal denuded of its mucous membrane was that generally preferred in finishing the operation, and the inconveniences of the sacral anus was commented upon by several speakers. Mr. Lynn Thomas said that he preferred an inguinal to a sacral anus.

On the third day, a number of papers were read. Mr. J. W. Thompson Walker showed an important specimen obtained from a patient who had died of cancer of the bladder, and who two years previously had had his prostate completely enucleated by the suprapubic method. It showed a small cavity where the prostate had been, and a complete absence of any tendency to stricture.

Mr. C. B. Keetley read a paper on "Appendicostomy," and stated that he considered the operation of value in certain cases of chronic constipation, for mucous colitis, in syphilitic ulcers of the colon, and in some cases of intussusception.

Mr. J. Berry showed a number of patients on whom he had operated for cleft palate, and tables relating to sixty-seven cases. He kept to the old operation, preferred to operate in the third year, and expressed strong disapproval of Brophy's operation.

Mr. W. J. Wheeler reported a successful case of the Talma-Morison operation for hepatic cirrhosis.

Mr. J. Jackson-Clarke read a paper on "Congenital Dislocation of the Hip." He stated that he had obtained very good results by the Lorenz manipulative method, since he had seen the method practised by Lorenz in 1903. Mr. Jordan Lloyd said that he thought the functional results were not so uniformly good as some surgeons were inclined to represent, and that parents should not be allowed to take too rosy a view of the prospects of the method.

THE ANNUAL EXHIBITION.

The Exhibition was located in the Drill Hall and Magazine Square in the ancient and picturesque portion of Leicester called the Newarke. The firms exhibiting numbered over a hundred, and the excellent catalogue formed a substantial guide-book of 155 pages. Mr. Guy Elliston, the Secretary of the Association, acted as manager of the Show. Generally speaking, the Exhibition was well arranged. We were pleased to find that aggressive wine and spirit merchants and other undesirable non-medical traders had been diminished, although not entirely excluded. The troublesome intrusions of showmen, often pronounced in previous years, were but little noticeable at Leicester. Altogether the Exhibition struck us as being a fairly representative one, and on the whole judiciously conducted, and we trust the self-repression and courtesy of the exhibitors will have brought them rich rewards.

In the space at our disposal, it is only possible to mention briefly the newer and more important of the exhibits. Many firms of manufacturing druggists were well represented. Messrs. H. and T. Kirby and Co. displayed "Purgen," a comparatively new non-irritating purgative; "Glycocols," or soft glycerine lozenges containing heroin, codeine, and other drugs; various tablets of compressed drugs, and their useful Pocket Pharmacopœia of selected remedies. Parke, Davis and Co. showed their excellent adrenalin preparations, thyroidectin, acetozone, a non-toxic antiseptic, their well-known Cascara compounds, "eudrenine," the new local anæsthetic and hæmostatic, and other of their well-established and widely-used products. Special reference should also be made to their new all-glass aseptic nebuliser, which appears to be convenient, effective, and economical. Messrs. James Woolley, Sons and Co., of Manchester, made an excellent show of their goods, including Akolethe, cataplasmin, an effective form of poultice in which the hygroscopic properties of glycerin are present with the reducing action of potassium iodide, ethereal antiseptic soap, sol. sodæ phenatis, an antiseptic and sedative solution used in dental operations, and other well-approved preparations. Wyleys, the widely-known manufacturing chemists of Coventry, exhibited ruscol, a new organic compound of bismuth and birch tar, useful in dermatological work; neuracetin, an agent for relieving pain and reducing temperature; various heroin compounds, and many medicinal syrups, liquors, and other elegant pharmaceutical preparations. Messrs. Andrus and Andrus showed their much-advertised hemabloids; formolyptol, a pleasant formaldehyde preparation; and kola-cardinette, a new and elegant cordial and stimulant. The Bayer Co. made a brave show with their many mysterious synthetical and fancifully named preparations, including argyrin, aspirin, the very useful heroin, jothion (containing 80 per cent. of iodine), somatose, tannigen, trional, and veronal. The Angier Chemical Company exhibited their well-known petroleum emulsion with hypophosphites. Fairchild Brothers and Foster displayed their "Fairchild Digestive Products"—Lecithin, "Pepsenica," "Panopepton," and their various "zymine" preparations. The latter are now to appear in tablet form under the name of "pepule." Arthur and Co. exhibited Bromaurum and a number of cosmetic applications. Messrs. Burgoyne, Burbidges and Co. displayed a selection of their goods, including Calodal, Collargol, Creosotal, Duotal, Salocreol, Xeroform and other well-established medicaments. Philip Harris and Co., of Birmingham, showed many useful pharmaceutical specialities, including Ehrendorfer's pencils of iodoform, and a series of excellent concentrated mixtures. Messrs. Newton, Chambers and Co. had many manifestations in solid and liquid form of "Izal." Messrs. Oppenheimer, Son, and Co. pushed their "Palatinoids," and their convenient "Aseptules" of renaglandin were again to the front. Messrs. C. J. Hewlett and Son had a goodly show of elegant preparations, including the well-known Mist. Pepsinæ Co. c. Bismutho, Mist. Terpin Heroin Co., Lin. Betulæ Co., Antithermogen, a useful antiseptic and absorbent, and "Creosalgen," a powerful antiseptic. The Charles H. Phillips Chemical Company displayed their mild neutraliser of hyperacidity and convenient laxative, "Milk of Magnesia." Messrs. T. Howard Lloyd and Co., of Leicester, exhibited many useful preparations—Sapthol, an antiseptic soap powder; Malto-Eastonii, effervescing "solulettes," "occules," most useful in ophthalmic work; and the very ingenious and convenient "inklets," or compressed ink tablets, which we are ourselves using with great satisfaction. The Jeyes' Sanitary Compounds Company displayed "Cyllin" in all its many formed glory.

Foods and food products, as usual, monopolised much space and clearly showed that the problems of diet and nutrition were far from being solved. The Maltine Manufacturing Company, in addition to their many "Maltine" preparations, exhibited the well-known Carnrick Liquid and Beef Peptonoids. Cheltine Foods and Chocolate, Limited, displayed various forms of "food," biscuit and bread, and their malted milk-chocolate appeared to be particularly nutritious and palatable. Brand and Co. were well advertised in their many compressed and concentrated juices and jellies. The Manhu Foods Company made a speciality of diabetic preparations. Keen, Robinson and Co. did not allow us to forget the benefits of Robinson's Patent Barley and Groats, so much desired by infants and invalids. Moseley's Food, introduced by Foods Limited, of Stockport, is a new claimant for popularity and certainly after fully testing it we can testify to its highly palatable and nutritious properties. Cadbury is a name which almost forms an integral part of the British Constitution, and the well-known cocoa and chocolate of this firm are too greatly prized to need more than a passing reference. Van Abbott and Sons, and Callard and Co. showed samples of their starchless and sugarless preparations, which are certainly useful in many cases of diabetes and obesity. Horlick's Malted Milk had an extensive stand where samples were very freely provided. M. Hoff, of Hamburg, displayed his malt extract and palatable tonic, "Ironal." Broomfield and Co. showed Albene, the vegetable fat. Henri Nestlé was to the front with the widely used condensed milks and comparatively new "Milo" food. The Aylesbury Dairy Company made a good exhibit with their various milk preparations, and "Pollyta," a new solid milk food for infants. Mellin's dietetic preparations also had a stand. "Virol" and

"Bovril" were both well represented. Armour and Co., of Chicago fame, exhibited their various glandular extracts in powder and tablet form, and preparations of thyroid extract, soluble beef and other meat products, for which they are justly celebrated. The "Veda" bread and oat food appeared to be particularly palatable. Reynolds' Wheatmeal Brown Bread was also exhibited. The Shredded Wheat Company had a complete demonstration of their methods of preparation.

Various waters and beverages were conspicuously represented. Among the waters reference should be made to the well-arranged exhibits of Vichy, Carlsbad, Contrexeville "Pavillon," Wildungen, Vittel, Apenta, Apollinaris, Johannis, Perrier, and Friedrichshall.

This year's Exhibition was particularly noteworthy on account of the many excellent displays of surgical goods, hospital appliances, and sanitary equipments. Messrs. Down Brothers showed all their new forms of hospital furniture and surgical instruments. Arnold and Sons had an excellent exhibit of many fresh surgical instruments. Mayer and Meltzer displayed their latest appliances for laryngological, rhinological, and otological work. Lynch and Co. showed many medical appliances and hospital apparatus. Messrs. John Weiss and Son had a useful exhibit of the newest improvements in surgical instruments. Messrs. Allen and Hanbury showed the new cerebro-spinal manometer, suggested by Mr. F. C. Eve, the uterine dilator of De Sergneux, and other novel appliances. Messrs. S. Maw, Son, and Sons had a representative display of instruments. C. A. Hoefftcke displayed various forms of orthopædic appliances and artificial limbs. T. Holland and Son also showed their specialities for weak feet. Messrs. J. Defries and Sons exhibited a model of the Equifex Steam Disinfector, and many preparations used in disinfecting, pasteurisation, and also forms of the celebrated Pasteur filters. Pocock Brothers had put up a very elegant padded room, fitted with aluminium gutter, self-acting shutter, protected door-hinge, and complete in every particular. Young's Hygienic Bin Company showed a large collection of galvanised steel bins most useful for hospital purposes. "Ronuk," Limited, the sanitary polish manufacturers, showed their special polishes and staining which are now used very extensively in hospitals and public institutions. The Cellular Clothing Company exhibited various forms of Aertex cellular clothing. D. T. Bostel and Sons had an interesting exhibit of their various patterns of the "Bostel Fire." The many forms of the "Lawson Tait" bedstead were well exhibited, and other varieties of bedsteads were shown by John and Joseph Taunton, the Longford Wire Co., and Isaac Chorlton and Co., of Manchester, the latter firm having on view the new "Lloyd-Smith" Sanatorium Chair. G. H. Zeal showed the useful and accurate "Repello" clinical thermometer. Messrs. Smith and Wade had an interesting exhibit of their Multinebuliser or compressed air outfit. Slack and Brownlow demonstrated the advantages of the "Brownlow" Filter, in which water passes through cylinders of porous porcelain. The Dowsing Radiant Heat Company had an extensive stand at which the benefits of their system were well demonstrated. The Sanitary Wood Wool Company exhibited the now well-known and widely used "Hartmann" dressings. The Liverpool Lint Company also showed various forms of tissue, gauze, sheeting, and other surgical requisites. A. De St. Dalmas and Co., of Leicester, had a good collection of medical plaisters and surgical bandages. A number of exhibitors showed electrical appliances and X-ray outfits.

It was interesting to note that stands had been taken by the Buxton Urban District Council, the Borough of Royal Leamington Spa, and Harrogate and Buxton Corporations, for the distribution of handbooks recording the climatic and other advantages of each as a health station.

A very good number of firms exhibited motors suitable for medical practitioners, among them being Humber Limited; the Central Motor Car Company; McNeil, Hutchison and Co.; T. H. Wathes and Co.; the Clyde Motor Company; and the Ryknield Engine Company.

Comparatively few medical publishers were represented, but stands were filled by Mr. H. K. Lewis and W. S. Saunders and Co.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, August 12th, 1905.

Immediate Treatment of Retention of Urine.

Acute retention of urine from different causes requires prompt treatment. The usual cause is due either to stricture, to hypertrophy of the prostate, or to acute gonorrhœa.

In cases of stricture the passage of a fine bougie is indicated, and around which the patient will urinate. The passage of this small bougie is frequently very difficult, and great patience, says Dr. Cathilin, is necessary. The penis must be drawn well forward and the bougie screwed in, so to speak, until the obstruction is passed.

It may be often necessary to insert three or four bougies up to the stricture, and one of them will finally pass through the small orifice, which is frequently excentric. This bougie will be left *in situ* twenty-four hours, when gradual dilatation may be commenced.

In patients suffering from hypertrophy of the prostate, a large catheter *à beguille* should be used, and when the bladder is reached it should be left *à demeure* three or four days, by attaching it to the hair on the pubis. The bladder should not be emptied completely, only six ounces of urine drawn off, and if it appears to be infected, four ounces of a solution of nitrate of silver (1 in 1,000) should be injected. The plug of the catheter should be taken out every hour or two to allow the patient to urinate.

In the acute stage of blenorrhagia, medical means should be preferred to the catheter; diuretic infusions, warm enemas, warm applications over the hypogastrium, warm baths, opium, &c.

In cases where, in spite of repeated attempts, the catheter cannot pass into the bladder, recourse must be had to tapping the bladder with a fine trocar above the pubis.

The point of election is the median line between the symphysis and the pre-vesical cul-de-sac of the peritoneum, and done with the usual precautions the operation is devoid of danger. The instrument to be used is that of Dieulafoy, or, preferably, Potain's aspirator. In this last case, the proper working of the apparatus should be proved beforehand. The needle (No. 2) should be passed through the flame and placed in a solution of phenic acid. The patient is laid on a table and pubes soaped, shaven, and disinfected. With the nail of the index finger of the left hand the operator marks a point on the median line at about half-an-inch from the symphysis, and, seizing the trocar with the right hand, he plunges it in at the exact spot marked by the finger of the left hand, perpendicularly and without fear. As soon as the bladder is penetrated, a sensation of vanquished resistance is felt. Aspiration is then adopted, and the liquid flows into the bottle.

The bladder should not be completely evacuated, for fear of provoking congestion of the bladder, or even intra-vesical hemorrhage, and in order to avoid the penetration of some drops of urine into the cellular tissue, the aspiration should be suppressed before withdrawing the needle.

Treatment of Inflammation of the Middle Ear.

Acute otitis of the middle ear in infants, children, or adults is always a grave affection, and claims immediate attention. In infants the diagnosis of otitis presents sometimes considerable difficulty, and in certain cases it is impossible.

In the course of some acute affection, the child cries and moans for several hours or all night. Nothing seems to soothe it, and the mother, alarmed, sends for the doctor, who, after minute examination, fails to discover the cause of the trouble. One or two days afterwards, however, a drop of pus is found on the pillow, to the astonishment of the parents and the physician. The child is calm, sleep has taken the place of agitation and all ends well.

But, says Dr. Dubar, there are cases where the pus, not being able to find an issue through the tympanus, invades all the cavities it meets and reaches the meningeal membranes by the sutures, producing meningitis. With the first symptoms of the malady a few drops of

Olive oil sterilised, 2 oz.;
Resorcine, ½ drachm;

should be injected into each nostril by means of a syringe, while a plug of cotton steeped in

Resorcine, 15 grs.;
Phenic acid, 5 grs.;
Glycerine, 1½ oz.;

should be placed in each ear. The same treatment should be employed with elder children, while with adults the antisepsy of the nasal fossa is realised with the following ointment:—

Stovaine, 4 grs.;
Menthol, 6 grs.;
Phenosalyl, 1 gr.;
Vaseline, 5 drachms;
Lanoline, 3 drachms;

Weak antiseptic gargles should be renewed several times a day in order to clean out the Eustachian tube.

As soon as any painful sensation is felt in the ear in the course of some infection, five or six drops of

Resorcine, 15 grs.;
Phenic acid, 15 grs.;
Glycerine, 1½ oz.;

should be poured into the ear. When suppuration occurs the ear should be treated by a small plug of antiseptic gauze inserted as deeply as possible by means of a probe, and renewed daily if possible. Irrigations or irritating antiseptics should be avoided.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, August 12th, 1905.

AT the Medizinische Gesellschaft. Hr. Greef brought forward the

STATE CAMPAIGN AGAINST TRACHOMA.

He pointed out the great importance of epidemics of trachoma, especially in war time. That the cases in Berlin were only isolated did not lie in absence of local disposition. In East Prussia, a part that was settled by the Swabian introducer, Frederick the Great, and who had never intermixed with the surrounding population, there was no trachoma amongst them, although they were surrounded with the disease.

Since the Government campaign against trachoma had become organised no marked diminution in the disease had been proved. But in spite of this the pessimism that it had called forth was out of place. On the Rhine and in Southern Germany the disease that was very widespread in the last century had almost disappeared.

In the Eastern provinces, along with a general raising of the culture, an improvement in the water supply had been beneficial. Fresh water must be readily accessible with people so that several may not have to wash in the water used by persons suffering from the disease. What ophthalmologists can do for granulations had been taught by the Rhine statistics. Such eye surgeons were still wanting in the East. It would be necessary to support them by State subvention.

Hr. Herzog demanded the institution of a commission to inquire into the origin of trachoma, as well as the continuance of courses of treatment and regular examination at school. The improvement in wages was important, so far as to make people remain on the land, and thus avoid the influx of foreign agricultural labourers amongst whom trachoma was always present.

Hr. Kirchner reported that since 1898 more than 2,000,000 marks had been spent on the trachoma campaign, and not only the number, but also the severity of the cases in East Prussia had very materially diminished in that period. At the commencement some uniformity of view had to be formed amongst surgeons; by institution of courses of teaching medical men were brought to distinguish trachoma from the severe follicular catarrhs of the conjunctiva. Further, a systematic examination of all school children was undertaken, the diseased children were segregated from the others, and the further spread of the disease was prevented by improvement in hygienic conditions and especially in the erection of new school buildings. Village sisters were appointed at the cost of the State.

A great difficulty lay in the institution of "season workers," and this had its origin in that German spirit of wandering. The East Germans wandered to the West, and therefore labourers from Russia, Poland, and Galicia had to do the work, to return to their own countries after the harvest. They introduced diseases with them.

But in spite of all this they had succeeded in limiting the disease in East Prussia, and it is to be hoped that in other Eastern provinces (Silesia, Posen, and West Prussia) they would succeed as well, and so much the more as the new law, with its duty of notification, its compulsory treatment and disinfection, afforded powerful weapons that they had not hitherto been in possession of.

At the sitting of the Aerzteverein Reg. Bez. Stralsund, Hr. Glimm showed a number of patients who had been

TREATED FOR CARCINOMA OF THE SKIN BY X-RAYS

First as regarded the method of treatment.

Generally speaking soft tubes were used; hard tubes only in the case of thicker tumours and metastases under the skin. In small tumours the distance between the tumour surface and that of the tube was 5 ctm., with large ones 12 ctm. Importance was attached to a high number of interruptions with a weak current. The surrounding parts were protected by lead plates ½ mm. in thickness. Preference was given to one sitting lasting up to 90 minutes; shorter, repeated sittings were only made use of where the portion of the tumour and pain did not permit of the longer application. Over-dosage was avoided by the use of Holzknecht's chromo-radiometer, so that no burning on the skin took place in any way. Ten cases were treated, in most of which the cancerous nature of the disease was confirmed by the microscope. Five of these were carcinomata of the lip, four operable cases, cancer of the face, and one of inoperable cancer of the shoulder, with metastases 22 ctm. in length on the neck, breast, and arm. Smooth and complete recovery took place in eight cases. In one case of cancer, occupying nearly the whole of the lower lip, recovery took place only after a piece had been excised from the middle, that part being too thick for X-ray treatment. The inoperable carcinoma of the shoulder healed locally, the metastases also disappeared, but they returned. Of the eight first-named cases five after one application remained free, one after ten months. In the other three cases recurrence took place in 3, 3½ and 5 months; in only one case, however, was operative removal required. The last case shown was one of very large lupus, carcinoma of the cheek; after 5½ weeks' treatment there was already considerable improvement.

In conclusion he pointed out the following indication for X-ray treatment:

In the front rank were those cases of carcinoma of the skin, the removal of which by operative measures leaves unsightly scars and disturbs or destroys functions.

In the second came inoperable cases of mammary carcinoma, as amelioration of pain could always be procured and generally diminution in size of the tumour, with occasionally disappearance of all metastases.

Whether recurrences would be more frequent after X-ray treatment we should have to await further experiences for a decision to be reached.

Hr. Friedrich remarked that notwithstanding his scepticism regarding the treatment of carcinoma by X-rays, yet after the reliable reports of cases he felt that he had to prove it in the Greifswald klinik. Up to the present only superficial growths (many recurrent nodules therefore) had been accessible to the treatment; deep-seated neoplasms and especially those of the intestinal tract were absolutely excluded.

In mammary carcinoma also if the case were operable he always operated, preferring the certain to the uncertain way, whilst recurrences of many kinds could often be favourably affected by X-ray treatment. It was remarkable how pain in the vicinity of recurrent growths near nerves was favourably influenced occasionally. However dazzling the success in the cases demonstrated he uttered a warning against illusions in carcinoma in other situations.

Austria.

[From our own Correspondent.]

Vienna, August 12th, 1905.

Myxo-sarcoma.

Lorenz brought a young lad, æt. 13, before the members of the Gesellschaft, who was operated on four days previously for a malignant myxoma, which had embedded itself in the folds of the mesentery, destroying all the glands in its immediate surrounding. Its root was attached to the small intestine, which had to be removed, along with the growth, making a total of 220 cubic centimetres extirpated. The microscopical examination confirmed the diagnosis and justified early operation. The patient is now in a very promising condition.

Eiselsberg said that he had a very similar case about a year ago, occurring in a girl, æt. 12, on whom he operated without any sign of recurrence up to the present time. He was, however, inclined to characterise his own case after the microscopical examination as a lympho-sarcoma, and not a myxo-sarcoma as Lorenz had done.

Osteitis Deformans.

Latzko demonstrated another of those isolated cases put forward by Katholicky some time ago as not uncommon. The patient was æt. 35, with the whole skeleton in a form of transformation. Around the eyes were great barriers of osseous deposits as well as other parts of the cranium. The extremities were greatly deformed. This deformity had gone on since he was nine years of age, and was still proceeding in spite of all efforts to check it.

Latzko thought there was one symptom pathognomonic in this osseous thickening which distinguished it from osteomalacia or multiple myoma, viz., the great thickening of the corticalis.

Latzko further presented two other cases of puerperal sequelæ on whom he had operated. The first was a long firm band of fibrous tissue—not a thrombosed spermatic vein as he emphasised, but a firm band of fibrous tissue.

The second was endometritis septica necessitating supravaginal extirpation of the uterus with a retroperitoneal pedicle.

Spinal Analgesia.

Preleitner next gave the members his results and recommendations for operating with these so-called analgesics. He thought this form of operation best suited for children where heart failure and dangerous bronchitis was often produced by the inhalation of chloroform. Again, the patient being conscious swallows any offending matter which might under gas be carried into the lung and produce pneumonia. Lastly, no narcotiser is required with the operation, which is often a great advantage.

The objections raised against this form of operating are the temporary after-constituents of the urine associated with incontinence.

In the discussion, Clairmont said he had now performed forty operations by the spinal analgesia method, and met with incontinence five times only. This incontinence is probably due to the formation of a hæmatoma.

Eiselsberg was more cautious in the use of these analgesics and warned operators of their dangers in the lumbar region. He finally asked if there were any real need for such a risky operation.

Fraenkel thought the spinal analgesia was only a minor part of the operation, as the very sight of operating filled the child with terror and excitement to get free from its persecutors. To his mind, it was more important to remove psychical quality than the algesic. He had not seen a child operated on under this local anæsthesia, but presumed the child could not be easily controlled.

Preleitner assured Fraenkel that the child lay quite quiet and often asleep when the operation was going forward. His own opinion was that the pneumonia in children was a serious factor to deal with, and could be avoided under spinal analgesia. Again, the incontinence is not due to a hæmatoma but rather to the action of the eucain.

Operating Theatres.

THE FRENCH HOSPITAL.

The Question of Searching for the Appendix in Acute Iliac Abscess.—Mr. Edmund Owen operated on a governess, æt. 20, who on admission was extremely ill, and exhausted by constant vomiting. She had had an attack of appendicitis five years before, but had been quite healthy ever since. Three days previous to her coming to the hospital she had been suddenly taken with acute pain in the abdomen and vomiting. On admission her temperature was 102°, and her pulse was 120. Her bowels had not been moved for three days. The abdomen was distended, rigid, and did not move on respiration. A fulness, which was very tender could be felt in the right iliac region. She was at once taken into the theatre and operated on. The appendix, which was gangrenous, was removed, and a large abscess was found extending from it into the pelvis. There had been no attempt whatever on the part of Nature to wall off the abscess, but the pus was bathing the coils of intestine in the lower part of the abdomen, and was welling down into the pelvis around the uterus and bladder. The pus was mopped up with swabs of gauze, and the operation was completed by the insertion of a large drainage tube into the bottom of Douglas's pouch,

Mr. Owen remarked that it was by no means rare to find a foul abscess tracking without delimitation amongst abdominal and pelvic viscera, and that although, of course, the condition was a desperate one, still, if the cavity and its soiled contents were well cleaned out with dry swabs, and efficiently drained, the cases did well. A recognition of the fact that so large a proportion of these desperate cases recovered, had made him much bolder in his search for the appendix in those operations in which a mere incision of an abscess did not reveal its presence. At first he used to content himself with opening the abscess, and making but a timid search for the appendix, which if found, was promptly removed. To leave diseased appendix unremoved was always a source of regret to an operator, yet often the surgeon had unwillingly to come to the conclusion that it was, on the whole, safer not to search for it. But a diseased appendix unremoved was an ever-present source of danger, and though, after having given rise to one acute abscess it often gave no further trouble, still the patient would have been far safer without it. The majority of persons who had apparently entirely recovered after an incomplete operation upon an acute appendicular abscess were disinclined to be again put upon an operating-table in a quiet interval, in order that the lurking appendix might be removed. And though in most instances the appendix gave no further trouble, still, at any moment, it might again cause an alarming conflagration. Taking, thus, all things into consideration, Mr. Owen had become more aggressive in his dealings with acute appendicular abscesses, and was fully satisfied with the way in which the end had justified the means. The presence of an acute appendicular abscess, he remarked, apparently caused most of these patients to spontaneously undergo a process of auto-immunisation against the toxins set free by the growth of the septic micro-organisms, and though one would not desire to search for the diseased appendix in the acute stage, it was nevertheless, in many of these anxious cases the right course to pursue.

The patient made a rapid and complete recovery.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 16, 1905.

MISTAKEN DIAGNOSIS.

UNDER the heading of "Mistaken Diagnosis," newspaper readers are being somewhat widely entertained in the waning journalistic season. It is obviously the duty of the lay journalist to keep his finger on the pulse of the public so as to learn therefrom the diet likely to prove most attractive to his audience, needless to say, quite apart from its wholesomeness. From long experience he has learnt that anything derogatory to medical men forms a subject of perennial catchpenny attractiveness. Why the public should love to hear of the shortcomings of a profession to which they owe so much is somewhat of a mystery. But so it is, and the fact that "nearly" 2,000 cases of mistaken diagnosis occurred last year in patients admitted to the Metropolitan Asylum Board hospitals has been hailed with delight by jaded sub-editors. Unlikely as it may seem the matter was brought before the public by a medical man, Professor W. R. Smith, chairman of the Statistical Committee of the Board. To that statement he added the calculation, based upon a period of average detention of three weeks, that the total cost of these erroneous notifications to the ratepayers reached £12,000 for the year. As a former medical officer of health, Dr. Smith must be fully alive to the fact that a margin of error is inseparable from the circumstances of the case. It is important from many points of view to isolate an infectious patient in the early stages of his malady, that is to say, at the very time when it is most difficult to form a really trustworthy opinion as to the precise nature of the disease. German measles is not infrequently mistaken for scarlet fever, and a few weeks since we heard of it being pronounced enteric fever, with the result of the infliction of a vast deal of unnecessary anxiety and expense to the friends, and of injury to the reputation of the medical attendant. This latter complication is not likely to occur where private patients above the hospital class are concerned, for the medical attendant is able to give a guarded opinion and await further developments. But when the patient has to be hurried off to a hospital he has to act upon observation that is often inadequate, and at times absolutely misleading. Atypical cases of specific infective fevers are of constant occurrence. For instance, let the average man in the street think of the appalling nature of the pitfall presented by a case of measles or of scarlet fever without rash. Then again the earlier stages of enteric fever are often suggestive of anything but the real malady. We have personally known men of the highest eminence in the profession, men whose lives have been spent in the conscientious study of medicine in hospitals, and medical schools, who have made disastrous errors in the diagnosis of typhoid fever. In other words, medicine has not yet attained the position of an exact science. Nor, so long as the conditions of experiment vary, does there seem any prospect of getting rid of fallacy in the notification of disease. The disease itself varies so greatly that its usually characteristic features may be marked or absent, the constitution of the patient varies, the experience of the medical man varies; in short, precise data are often not available upon which to form a reasoned conclusion. In what are called "typical" cases, there is no suggestion, so far as we know, that many errors are made. That general practitioners do make, and will always make, a certain number of errors when called upon to form definite conclusions upon imperfect grounds is natural and excusable. It would be more to the point were Professor Smith to inquire how many errors were made by members of the hospital medical staffs. He appears to assume that the latter are absolute, just as there is no appeal against the finality of their diagnosis. As a matter of fact we believe that even under existing circumstances most favourable to an accurate and deliberate diagnosis such mistakes do occur-

Obviously it is extremely difficult to get to the facts of such occurrences in the Metropolitan Board Hospitals. Applying our argument based upon the unavoidable margin of error involved, such mistakes must obviously follow on the part of the hospital medical staff which sits in judgment on the general practitioner. On the whole there seems little wisdom or tact in obtruding matters of this kind which are unavoidable, but which cast a gratuitous slur upon an honourable profession.

THE TRUE RE-ORGANISATION SCHEME OF THE I.M.A.

THE misleading manner in which the proceedings of the re-organisation committee appointed by the Council of the Irish Medical Association were reported in the *Journal* of the association for July, is bearing fruit, as is shown by a resolution passed by the Cavan branch. This branch entirely disapproves of the majority report "*which would do away with branch representation*," but it agrees with the minority report recently issued. So far from the majority report doing away with branch representation, it proposes that the election of branch representatives shall be an essential condition of branch existence; indeed, up to the present, there has been no branch representative—nor in the so-called minority report has any proposal for branch representation been made. It is true that 32 county councillors are selected, and the minority propose to curtail this system: but the county councillors are not elected by branches, nor need they be proposed by them. They can be nominated by any member of the association, and are elected by the members in each county, whether they belong to a branch or not. The majority report proposes that the General Meeting shall be the governing body of the association; that the vicious system shall cease, by which the Council is nominally the governing body, but which actually vests the entire control in a Committee of Council, which has brought the association to the verge of a financial crisis, and which, as was demonstrated in the Evatt case, over-rules the Council and sets its authority at nought. We wonder if the Cavan branch has considered the absurd Committee of Council suggested by the four dissentients: A president, who every second year shall be a country member, and may not be able to attend regularly; four vice-presidents, also unable to attend; one honorary secretary; and one co-opted member. By such an arrangement the entire working of the association would practically pass into the hands of the honorary secretary and of the co-opted member. We do not blame the Cavan branch for falling into error as regards the proposal of the majority of the re-organisation committee, nor for assuming that the documents conceived and issued by the minority without the knowledge of, or consultation with, the other members of the committee, was really a minority report — an assumption probably due to the statement in the July number of the *Journal* that there "voted for the county representative scheme Drs. Delahoyde, Donnelly, Hickey, and Tobin." The Cavan branch could not know, that neither this nor any county representative scheme was ever submitted to, or voted on, by the committee. What was before it was Dr. Donnelly's scheme of grouped branches (*vide* page 201, *Journal*, July) and this, after very careful examination by the committee was found to be unworkable. We fear that among the many pressing needs of the association is a scheme by which the editing of this *Journal* will be amended. It is not too much to expect that its statements of facts should at least approach accuracy, for it is most necessary that the official organ of an association should report accurately its proceedings and should support loyally the policy of the association.

MEDICAL EXAMINATION OF VOLUNTEERS.

MR. ARNOLD FORSTER must by this time be very sorry he issued his ill-advised circular, and its hardly better-advised supplement, ordering a general medical examination of the Volunteer Forces with a view to ascertaining their fitness for foreign service. Not only is the examination resented by the men, and a distasteful addition to the medical officers' duties, but it has been shown to be clearly *ultra vires*. To get out of the awkward position in which he had placed himself, the Secretary for War has had to resort to those ingenious devices of logomachy which have become so fashionable in high political circles at the present day. The circular directed officers commanding Volunteer corps to instruct their medical officer "to report upon the general physical standard of the men under their charge," in order that an opinion might be formed as to their fitness to serve abroad, and the requisite qualifications were set out at length. There were certain misunderstandings as to what exactly was meant by this circular, so a second explanatory one was subsequently issued. Mr. Arnold Forster immediately found that he had raised a hornets' nest about his ears, for his unfortunate circular violated not only the spirit, but the letter of the Volunteer Act, and it was obvious in so doing he could not enforce obedience to his commands. A Volunteer only takes oath to serve allegiance to the Sovereign in Great Britain, and this undertaking is further modified by the words, "according to the conditions of my service." The contract is one voluntarily entered into for a particular purpose, and the service rendered—and cheerfully rendered—is manifestly one that should be entitled to special consideration. Officials controlling the Volunteers should be the last people to overstep their authority; on the contrary, they should endeavour, as far as is consistent with discipline, to grant every indulgence to their subordinates. The person of all others to appreciate this fact should be the Secretary for War, who, as a civilian, might be, and theoretically is, more in touch with the sentiments of the country than a professional soldier. It is, too, into the all-important matter of discipline that this unfortunate circular makes inroads, for if the head of the War Office is negligent of his instructions, what sort of obedience can be hoped for among the rank and file of a sensitive and loosely-held-together force like the Volunteers? The strain of the order comes just in the most unhappy places, because in the case of objecting Volunteers, their loyalty is apt to be questioned, and unjustly questioned. In reply to questions in Parliament, as we have said, Mr. Arnold Forster has been reduced to pitiable makeshifts to maintain an obviously untenable position, his last point being that though the circular directed medical officers to report on the general physical conditions of the troops in their charge, it did not enjoin them to make an examination of the men. To the non-parliamentary mind this seems about as useful a process as making a pie without pastry, or playing "Hamlet" without the Prince ot Denmark. The order cannot possibly be carried into effect without a thorough examination of the men, and moreover, as such an examination would only be evidence of the present condition, if it is expected to be of any use as showing the number of men continuously available for foreign service it would have to be repeated annually. It is not easy to see, though the point is more debateable, in what respects a man fitted for home service would fail to be fit for foreign service, especially as in the entrance examination for recruits the medical officer will already have satisfied himself as to general physical ability and freedom from constitutional disease. The order has been widely resented both in the Volunteer force itself and among certain sections of the civil community, and what we ourselves are principally concerned with is that through an unfortunate concatenation of circumstances, a matter of such supreme necessity as the medical supervision of troops should have been brought into disrepute, some men even refusing to allow the medical officers to examine them. Such an act, if the examination were made under due powers, would be highly reprehensible, and, indeed, would be subversive of all proper discipline, but as it is, the officers have to pocket the indignity because of the blunder of their superior. Moreover, the work thrown on the medical officers themselves is very arduous as the examination of a battalion of soldiers is no light task if the work be done conscientiously; and when, as in many cases, the bulk is to be done during the annual training, this little outing, which generally constitutes an appreciable proportion of the doctor's holiday, will be turned into an incessant grind. If the examination is really to become an annual institution, it is clear that there will be but few medical men with the time or opportunity to perform such an onerous task, and it would be well for a clear statement on this point to be forthcoming, so that Volunteer medical officers may know where they are. We agree, as all sensible people must agree, that a sick soldier is much worse than no soldier, but there are other and more statesmanlike ways of insuring against physical breakdowns than by issuing orders which are contrary to the spirit of the King's Regulations, and invite open disobedience. We hope it is not too late for some wiser course to be followed.

Notes on Current Topics.

Hospitals from Inside.

Familiar as we are with hospital life from one point of view, there are some sides of it to which we are quite blind. It is, therefore, almost with the feeling of exploring an unknown land that one reads the sketch of hospital life "An In-patient" contributes to our contemporary, *The Pharmaceutical Journal*. He sets nothing down in malice, and he shows himself both observant and reflective, so that his criticisms and suggestions may be taken in good part. It is interesting to notice how "An In-patient's" mental attitude alters during his stay in hospital; from the homeless, unnerved wretch, who feels his last hope of retreat gone when, on his arrival in the ward, he has to deliver his boots to the charge of the nurse, he gradually develops into the contented and comfortable convalescent, sensible of and grateful for the cleanliness and attention, the kindness of the nurses and the stoical skill of the house surgeon. The most trying part of his ordeal to "In-patient" was the daily dressing of his wound, with regard to which he says—though surely his experience is unfortunate—"no effort is made to soothe the pain and distress." He points out, too, that "it is also a very trying and unnecessary experience to have to sit round and witness the dressing of the other inmates, sometimes unscreened." This is quite true, and is just such a point as is likely, through force of habit, to be overlooked by those responsible for ward management. Nevertheless, in spite of some avoidable faults and many inevitable discomforts, "In-patient" has no doubt that "to the majority of patients the life becomes, after the first painful days, a perfect elysium."

Beware of Sunlight.

The ludicrous aspect in which science—or scientific pretension—is, from time to time, placed before the critical view of the mobile population of our metropolitan thoroughfares is, of course, ever and anon furnishing stimuli for the risorial faculties of our brethren of the lay Press. The liveliest opportunities for such enjoyment are necessarily furnished by the flatly contradictory statements and opinions offered by the champions of certain semi-metaphysical views of physical subjects. When such questions are of a nature which precludes the possibility of directly applying experimental tests of a decisive value, there obviously must remain more or less marginal scope for discussion and contradiction. One of the most recent examples is in regard to the value of sunlight—physiologically and therapeutically. A correspondent of one of our lay contemporaries has been chuckling over the antagonistic views of the representatives of scientific illumination and leadership. He calls attention to the fact that not very long ago we had been hearing a great deal of the antiseptic value of sunlight, especially of the violet rays. We were told the fogs which were so prone to envelop our cities periodically, and the smoke-pall which shades off the sunlight perpetually, were hygienically most objectionable, from the fact that they it was which effectively screened off the health-giving violet rays; and we were told votaries of natural sanitation had been subjecting themselves to considerable physical inconvenience, and even discomfort, in order to take sun-baths, in the fond belief that they were administering to themselves a most excellent tonic. Now, however, strikes in a learned doctor with a volume on the subject of tropical light, who informs the startled world that broad sunlight, especially the rays referrable to the violet end of the spectrum, is a most unhealthy thing. According to this hygienic iconoclast, exposure to unclouded sunlight makes languid the most vigorous human animal, damages his digestion, and generally upsets his whole internal machinery. The proper and natural environment of the human form divine is one of semi-darkness. Instead of flooding our rooms with sunlight, we should carefully shut it out. All races except Europeans know enough to come in out of the sun. And so, after all, concludes our now happy—as well as patriotic—contemporary, "our smoke and fogs are a blessing, albeit in an impenetrable disguise."

Standardisation of Drugs.

Not the least useful of the annual congresses which have recently taken place was that of the Pharmaceutical Association at Brighton. The pharmaceutical chemists are so intimately allied both in aims and methods with medical men, that none of their doings can be without interest, and the modern pharmacist is, like the modern doctor, a man of science and exactitude to a degree that presents a marked contrast from the state of things fifty years ago. An earnest and learned address was given by Mr. Naylor, the President, on the standardisation of drugs, a subject which, in the rush of other matters is apt to fall outside the ken of medical men, on account of the technicalities that surround it. The matter, however, is one which, though the clinician may not be able to follow it into all its ramifications, is of vital importance in the progress of medicine, and one with which he should keep closely in touch. Modern pharmacy, though relegated for the most part to the chemist and the Pharmaceutical Committee of the General Medical Council, looks to the physician for its stimulus and for the endorsement of its results, and it is well that the painstaking efforts of the men who endeavour to place it on an exact and scientific basis should be both recognised and encouraged. Much of the discredit that has been cast on the galenicals by the pathological school is undoubtedly due to the variations that have occurred in the strengths and potencies of preparations at different times, and it cannot be too strongly borne in mind that unless all drugs are standardised, a factor of error of such magnitude is introduced into therapeutics as may vitiate all conclusions derived from clinical observation. As Mr. Naylor pointed out, some of the principal matters for determination that should be constantly watched for in the administration of medicines are whether the mixed alkaloids of a given drug act as well as, or differently from, a preparation containing the leading ingredient alone, and, again, whether an alkaloid derived from one source is similar in action to a chemically similar one derived from another. Pharmacy, said Mr. Naylor, will continue to be largely what the pharmacist qualifies himself to make it, but it will also, in response to a natural law, be entirely what the doctor demands that it shall be.

Business and Pleasure.

It may be supposed that the British doctor, like the average British citizen, appears to his neighbour of the *entente cordiale* to take his pleasures sadly, but at any rate he is now given the opportunity of doing otherwise, and of gaining a little knowledge into the bargain. The Medical Study Trips that are organised by Dr. Carron de la Carrière, of 2, Rue Lincoln, Paris, are pleasant functions, and this year a journey, under the management of Dr. Landouzy, is being planned to take in the chief places of South-West France. The trip starts from Luchon on September 1st, and an attractive programme has been mapped out in quite the best Polytechnic style, showing how every hour of the next fortnight will be spent by the "adherents." Capvern, Bagnères-de-Bizarre, Pau, Eaux-Chaudes, Salles-de-Béarn, Biarritz, Hendaye, and many other places will be visited, the tedium of travelling, lunching, and dining being diversified by conferences on hydrotherapeutics and balneology. The beautiful country in the High and Low Pyrenees will be traversed pretty thoroughly, and by those "adherents" who do not know its charms it will be found full of interest and wonder, while to Englishmen there will be added the sense that in their little way they are helping by their presence to forward the great cause of international amity. Considering all that will be done for the party the inclusive charge—£12—seems little enough, even though it does not reach quite the level of that miracle of cheapness—"A week in Lovely Lucerne." At any rate, to the medical man who prefers a strenuous holiday to a fortnight's golf at the sea-side, the trip may be commended, and he can be promised that at least he will be spared any uncertainty as to how to spend his time, for the programme has been made to include even such items as "arrivée vers 6h. 20—Diner—Coucher."

A Sane Woman in an Asylum.

It seems hardly credible that in these enlightened days it should be possible to hale off a sane woman from her daily life and shut her up in a madhouse. Yet such a thing was done in England not longer ago than March, 1905—witness the circumstantial and uncontradicted evidence given last week in the Appeal Courts. The name of the lady concerned did not transpire, but she enjoys a high social position, and by a more than usually common-sense act of grace on the part of the lawyers she was permitted to appear in Court under the initials, "F. M. C." It appears that the solicitor of her family came to the sapient conclusion plaintiff was not in her right mind. He communicated that belief to the solicitor who at that particular time was acting for the appellant. The lady had an income of £3,000 a year, and had recently successfully prosecuted a divorce petition against her husband. On the very day she had arranged to draw £4,000 and pay off her debts, the two solicitors took a magistrate, a coal merchant, to her house to certify her as a lunatic. He, however, was not qualified to sign a reception order, and the signature was obtained of another magistrate, who did not even see the lady, who was promptly taken off to an asylum in a special train. The Commissioners of Lunacy released her on April 17th. We do not envy the position of the solicitors, magistrates, and medical men concerned. Although they may have acted in good faith, they have clearly hurried themselves into a position of a serious and invidious nature. The comforting feature of this sordid transaction is the decisive action of the Lunacy Commissioners.

Army Medical Service.

In the whole of that incongruous patchwork that has resulted from the efforts of successive Secretaries of State to produce an organised and effective British Army, we can at least point to a genuine advance having been initiated by Mr. Brodrick in the condition and functions of the Royal Army Medical Corps. Lord Roberts' recent revelations concerning the fitness of our forces to take the field against a European foe are discomforting in the extreme, and though it must be left to other agencies to take steps to remove this reproach, there is one factor in the situation which affects the medical profession profoundly. We mean, of course, the statement that the resources of the Royal Army Medical Corps—in spite of all the increases that have resulted from the improved pay and status of the Corps—is only capable of ministering to the needs of a force of 55,000 men. This statement was so astounding that it was properly made the subject of a question in Parliament, and elicited a highly unsatisfactory reply. Mr. Arnold Forster replied that the War Establishments of the Army provided for a considerable number of the medical staff being civilians, but as the numbers of these available on mobilisation were not determined, it was not possible to give figures. He was aware that the strength of the Royal Army Medical Corps was not adequate, but the Army Council were making every effort to increase it. Here we find two alarming admissions—first, that although the War Office rely on civilian medical aid in time of war, the War Minister has no idea of how many surgeons may be counted upon (and therefore presumably no machinery for this organisation exists), and, secondly, that, in spite of this expected complement of civilians, the Royal Army Medical Corps is inadequate. After the shocking, heart-rending muddle of military medical affairs in South Africa, it might have been hoped that steps would have been taken to place the possibility of anything of the kind happening again beyond the region of doubt, and now we find that the circumstances have only to be re-enacted to ensure a similar breakdown. How long will a "business" people stand conduct of this kind in their chosen representatives?

The Plague.

The apathy of the House of Commons when Indian affairs are under discussion is proverbial, and it is not a pleasant reflection that because little or no party capital is to be made out of the details of the administration of our great dependent Empire, members allow them to pass unquestioned and unheeded. We had hoped that the efforts that have been made in one or two quarters to direct attention to the appalling waste of human life that is resulting from the increasing ravages of the plague in India, would have brought forth some definite and strong policy on the part of the India Office. The facts as regard the plague have certainly not been brought home to the public in this country, or we do not hesitate to say that they would never allow an epidemic to ravage India and carry off over a million of their fellow-subjects yearly without any steps being taken to oppose it. It may be an *opprobrium medicinæ* that the methods of infection in plague are but ill-understood, but certain definite facts have already been established on which a good working start might be made. Moreover, to speak from the scientific point of view alone, an amount of material is presented to the would-be investigator the like of which he has never had before, and it is all practically being wasted. If the Indian Government are waiting a clear scientific lead, they should endeavour to obtain it by employing a large staff of investigators even if the cost were great, their present efforts in this direction being so half-hearted as to suggest that they are only acting from motives of political expediency. The plague which is decimating India, and threatens almost to overwhelm it, is not matter for fatalistic jeremiads, but a foe to be resolutely met and conquered. It is awful to contemplate the ultimate condition of the country if its present rate of increase is maintained, and of a fall there is yet no sort of indication.

Medicine and Surgery of the Japanese Army

The whole wondering world has been brought, or forced, to admit the astonishing advances which have been made by the Japanese within a quarter of a century in the mechanical devices and scientific methods and theories adopted—so suddenly and unexpectedly—from their Western contemporaries. In no department of science or art has this development been more electric in its velocity than in those of medicine and surgery. "Nippon the Conqueror" has bettered the teaching of her instructors; and if she has stunned the Russian foe by her skill and agility in warfare, she has made a correspondingly forcible impression on her English and American friends by her hygienic care of her soldiers in the camp and on the march, and her medical and surgical treatment of the sick and the wounded respectively. We have rarely, if ever, perused a more impressive testimonial to these facts and opinions than that furnished by the pages of Dr. Seaman's recent book, "From Tokio through Manchuria with the Japanese." It is not usual to find a patriotic citizen of the great Western Republic admit the superiority of another nation in the methods and appliances which specially call for mechanical skill and precision, combined with fertility of advice and originality; but Dr. Seaman does not hesitate to do so. Himself a surgeon, U.S.V., he served in the Spanish-American and Philippine wars, and with the allied armies through the Boxer campaign. The main object of his recent visit to the Far East was the study of the Japanese treatment of the sick and wounded in the war. After dwelling on the ravages of "the silent foe" in the campaigns in which he had previously served, he summarises by informing his readers that where shot and shell slew their thousands, microbes and insanitary conditions slew their tens of thousands. And of the latter he tells us that the Japanese have made a "triumphal conquest." "Japan is the first country in the world to recognise that the greatest enemy in war is not the opposing army, but a foe more treacherous and dangerous—preventable disease . . . The medical officer is omnipresent. You will find him in countless places where, in an American or British army, he has no place, He is as much at the front as in the rear. He is with the first screen of scouts with his microsope and chemicals, testing and labelling wells, so that the army to follow shall drink no contaminated water." And he bitterly contrasts the six weeks of the Spanish-American war, when the mortality from bullets and wounds was 268, while that from disease reached the appalling number of 3,862, or "about fourteen to one." "Banzai Nippon!" is avowedly the theme throughout of Dr. Seaman's book. Must not every Western lover of our profession re-echo the national war-cry?

Five o' Clock Tea.

Afternoon tea has long been of all things a British institution. As a social event it is of no small importance, its shortness and informality being specially attractive to leaders of the strenuous social life. Whether in drawing-room or garden tea is a lightsome meal possessing attractive features of its own. Under the influence of the fragrant cup rigidity unbends, and who knows what confidences may not ultimately be exchanged while quaffing the gentle stimulant? There are signs, however that the afternoon function is undergoing a slow sea change, inasmuch as it is once more assuming the character of the more homely regular meal of our grandfathers. In other words, it is becoming a less hurried and a more substantial affair. It is asserted that motoring is chiefly responsible for this change, at any rate among the wealthier classes of society. At the other end of the social scale, and also among many of the middle classes, five o' clock tea has never been anything else than a regular sit-down meal around the family table. For late diners this innovation may be regarded as serious, for another square meal is thereby added to a list already too long. From the medical point of view this state of affairs deserves consideration. Fortunately much meaty food is rarely consumed at tea-time, but on the other hand, there is the danger which may result from the consumption of too much tea and sugary fare. The appetite, moreover, may be rendered a trifle less keen for dinner, though there is a modern tendency to postpone still further the hour for that meal. If the tea hour snatch a few minutes' rest for the restless, it will have achieved some good for society,

Synæsthesia.

Although the condition known as synæsthesia is one which, up to the present, has attracted the attention of psychologists rather than of medical men, nevertheless it should not be without interest to us. The term itself is somewhat difficult to define, but it is most usually applied to the phenomenon of a secondary sensation or subjective impression accompanying an actual perception. The familiar instance of shivering at the sound of a pencil squeaking on a slate is, perhaps, as simple an example as can be given. In many cases, however, certain visual are accompanied by auditory sensations, or *vice versa*. For example, the sound of the vowel "a" may give rise to a sensation of white in one subject, of black or blue in another. The sound stimuli, moreover, which call up visual accompaniments, may be very serious. In one person it may be the vowel sounds, in another the tones of a speaker's voice or of a musical instrument. It is said indeed that some violinists have been able to tune their instruments by fixing the attention on the colour corresponding to the pitch they are aiming at, and that singers have pitched their voices accurately by the same method. Dr. Lee Smith, of Johns Hopkins, has recently published an interesting account (*a*) of a family in which the condition was hereditary, occurring in a father, his five children and a niece. The father, ever since childhood, has associated a definite colour with each letter of the alphabet, some appearing white, some reddish-brown, and so on. One daughter associates colours not only with letters, but with musical tunes, and with sensations of touch, temperature and pain. The conditions in the other members vary considerably in their detail. Professor Baldwin, who has studied the condition with care, thinks that synæsthesiæ are not to be considered abnormal or pathological, but that they belong rather to the realm of the idiosyncrasies.

Damages for Drawing Teeth.

A successful action for damages against the unqualified son of a dental surgeon has recently been settled under somewhat peculiar circumstances. It appeared that a Bradford cotton-spinner had suffered from excessive bleeding after tooth-extraction. Other members of the family had been troubled in the same way, and one had actually died, showing clearly the hæmophyllic constitution. He was introduced to the defendant, who told him the operation could be performed without risk by means of a new American invention. Six teeth were afterwards extracted at the surgery of defendant's father. Profuse bleeding followed, and the plaintiff was under medical treatment for some time. The operator was compelled to admit that he had never qualified as a dental surgeon, and he was mulcted to the extent of £125 damages. Had he been a properly qualified man, no action could have stood against him, for it is clear that no man can be responsible for results due to such an unavoidable and accidental complication as hæmophyllia. The principle involved is that a man performing an illegal act becomes answerable for its remote consequences. If that rule were more rigorously applied it would infallibly lessen the vast amount of unqualified medical practice that is now carried on in every class of the community. Let the public once appreciate that enormous damages are obtainable for any injury done to them by chemists, bone-setters, electricians, or any other non-medically qualified persons, and the paths of such offenders will be considerably narrowed.

Medical Omniscience.

The public, with all their partiality for specialists have a way—when it suits them—of expecting medical practitioners to possess expert knowledge in every branch of their profession. A doctor, in fact, is supposed to be a walking compendium of all knowledge embraced in medicine and the allied sciences, and when a rare or curious accident or disease is in question he must be able to expound it as if he had all the latest details of Teutonic research at his fingers' ends. It must be confessed that a good deal of the education in certain medical schools tends rather to produce the stamp of man that would fulfil these requirements, than to turn out well-armed practitioners capable of tackling ordinary disease in its commonest manifestations. But there are limits to human capacities, and even elderly practitioners may never have seen a case of ankylostomiasis or Madura foot. At an inquest held at Sheffield on August 13th, considerable interest centred in the question as to whether the patient had died of glanders. The man was a horse-keeper who six months previously had injured his leg while attending to a pony. The wound did not heal satisfactorily, and after much suffering he died of chronic pyæmia in the Royal Infirmary. Some of the ponies in the same colliery as that in which he worked had in the meantime been found to be glandered, and there seemed to be a strong inclination to attribute the man's death to the same disease. The medical witnesses, two resident officers from the Infirmary, were both closely cross-questioned as to the cause of death, and they both had to admit that neither of them had seen a case of glanders, and that the bacteriological findings were negative. Their evidence was to the effect that the patient had died of pyæmia, and the coroner in summing up informed the jury that they had to decide what disease had caused death ! The jury sensibly found in accordance with the medical evidence, feeling probably that if the doctors were unable to pronounce a case to be glanders, their own opinion was not worth much.

The Bonmartini Murder Case.

Members of the medical profession have been considerably involved in the notorious Bonmartini murder case, settled last week in the Italian criminal courts. It appears that the Countess, the wife of the murdered man, was in her earlier days attached to a medical student, but her affection was later bestowed upon the Count Bonmartini, whom she married. The marriage eventually became unhappy, and finally a separation took place. The brother of the Countess was Tullio Murri, son of the distinguished ophthalmic surgeon, Professor Murri. Inflamed at the real or supposed wrongs of his sister, Tullio formed a plot against the life of Count Bonmartini, and after vainly attempting to get the help of her lover, Dr. Secchi, he secured the active assistance of Dr. Naldi. The upshot of the affair was that the unfortunate Count was found stabbed in the Bologna Palace some three years ago. The crime has at length been brought home to five persons. Tullio Murri and Dr. Naldi have each been sentenced to thirty years' solitary confinement and ten years' police superveillance. Dr. Secchi and Countess Bonmartini were condemned each to ten years' solitary confinement, and a servant who was

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(*a*) *Johns Hopkins Hospital Bulletin*, July, 1905.

an accomplice to seven years. Tullio Murri was publicly denounced as the murderer some time ago by his father, the Professor. The terrible nature of the sentence is hardly realisable by those who are unfamiliar with the methods of Italian prisons. Inhuman and barbarous as our own penal system may be, it is a thousand times preferable to the gehenna of the Italian convict.

Sir Sydney Waterlow, at the Hospital Sunday Fund meeting last week, moved the adoption of the report of the Committee of Distribution which had been circulated to the council. The fund will not be closed till the end of October, and the contributions at the present time amount to £75,000. The generosity of Mr. George Herring and the £12,500 received under the will of Wyndham Francis Cook make the collection this year a record amount. Since the fund has been instituted, £1,382,160 has been collected for the benefit of hospitals. It is proposed to distribute the sum of £71,466 among 162 hospitals and 60 dispensaries, as shown in the appendix to the report, and Sir Sydney Waterlow moved that the awards be paid as soon as possible.

PERSONAL.

The seventh meeting of the International Congress of Hydrology, Climatology, Geology, and Physical Therapeutics will be opened at Venice on October 10th, under the honorary presidency of the Italian Minister of Public Instruction, and the acting presidency of Professor A. De Giovanni, of the University of Padua.

The offer of Sir Alfred Jones, of the Liverpool School of Tropical Medicine, to send Professors Ronald Ross and Rubert Boyce to the Mayor of New Orleans to deal with the outbreak of yellow fever in that city, has been gratefully accepted.

Professor Boyce sailed last Saturday on the "Campania" to investigate the epidemic of yellow fever at New Orleans.

The appointment of Dr. Alexander Cruikshank Houston as director of water examinations, Metropolitan Water Board, at a salary of £1,000 per annum, is announced. Dr. Houston is an Edinburgh graduate and took the degrees of M.B., C.M., in 1889; B.Sc. (Public Health) in 1891; and D.Sc. (Public Health) in 1892.

Mr. Gerald Balfour has promised a deputation who waited on him last week to have inquiries made by special officers of his department in the various centres where the rate of infant mortality was abnormal, and to consider their report carefully with the view to taking action to remedy the evil.

Through the trustees of the late Mr. James Holden, of Marsland, near Rochdale, the Delamere Forest Sanatorium for Consumption has received a grant of £10,000. One of the conditions being that six beds shall be set apart for the use of Rochdale patients.

The honorary secretaries of King Edward's Hospital Fund for London have received at the Bank of England the sum of £5,000 from the executors of Mr. Thomas John Bell.

An initial meeting of the council of the Liverpool Institute of Tropical Research was held on August 2nd, when Sir Alfred Jones, K.C.M.G., was unanimously elected chairman; Viscount Montmorres being appointed director, and Mr. Eric Drabell the economic botanist of the Institute.

Lieut.-Colonel F. G. Adye-Curran, M.D., F.R.C.S.I., has been elected representative of the Apothecaries' Hall, Ireland, on the General Medical Council for the ensuing year.

On leaving the parish of St. Germans, where he had practised for the past forty years, a handsome testimonial was presented to Dr. J. B. Kerswill by the Earl of St. Germans on behalf of an influential local committee.

The Council of the University of Leeds has received an intimation from Professor Edward Ward that, in consequence of the pressure of other matters, he feels constrained to relinquish the Chair of Surgery which he has occupied for six years. To the vacancy thus created Mr. Harry Littlewood, M.S.Leeds, F.R.C.S. Eng., has been appointed.

Dr. D. J. Thomas, medical officer to the Merthyr District Council during the past four years, has been appointed medical officer of Acton, and will begin his new duties at the end of September. His brother, Dr. D. C. L. Thomas, is medical officer for Stepney.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

BELFAST.

Alleged Boycott of a Medical Officer.—The perennial question of medical officers' holidays came up at a meeting of the Lurgan Guardians last week, and the dispensary officer, whose holiday was in question, Dr. Reid, of Derrvadd, near Lurgan, wrote that he could not get a *locum tenens* at three guineas a week, the sum allowed by the guardians, and further alleged that he was being boycotted by his medical brethren in the district because he refused to sign a resolution the contents of which he had never seen. He said that Dr. Pedlow, of Lurgan, had arranged to act as his *locum tenens*, but had backed out of the agreement, and now no other local man would take the work. After much discussion the guardians declared themselves powerless in the matter; they would pay three guineas a week to any properly qualified person whom Dr. Reid could get to act for him, but unless he could get someone he could not have his month's holiday. Metaphorically speaking, they cursed Dr. Pedlow with bell, book and candle, but as he is not in their service he is not likely to be a whit the worse.

Smiley Cottage Hospital, Larne.—The second annual meeting of the trustees and committee of this Institution was held last week, when a satisfactory report was presented. The patients treated during the year numbered fifty-four — thirty medical and twenty-four surgical, and fifteen operations were performed. There is so much Scotch blood in the Larne district that the people are somewhat more cautious than usual, and slow to take up any new idea, but they are beginning to realise the value of Sir Hugh Smiley's generous gift to their town, and no doubt the hospital, which is a model one in every respect, will soon be much more freely utilised.

By August 11th sixty-eight fresh cases of yellow fever had occurred at New Orleans, and five more deaths were announced.

The Board of Management of the Queen's Jubilee Hospital has received £1,000, from the trustees of the late Mr. G. F. Platt. Substantial amounts have recently accrued to the funds of this charity from various quarters, in addition to a handsome grant from the Hospital Sunday Fund.

Special Articles.

THE HOUSE OF LORDS AND PROFESSIONAL SECRECY.

McEwan *v.* Sir Patrick Heron Watson.

That thorny question, the legal relations of professional secrecy, does not seem to be made plainer by the decision of the House of Lords in the action for slander which has for some time been proceeding against Sir Patrick Heron Watson, references to which have from time to time appeared in The Medical Press and Circular. The litigation arose out of an action for separation on the ground of cruelty brought by Mrs. McEwan against her husband, as a preliminary to which she was in October 1901, at the instance of her law agents, examined by Sir Patrick Watson. His opinion, however, was unfavourable to her case, and he was not cited as a witness on her behalf. Two years after his first examination, on the eve of the trial of the action for separation, Sir Patrick again saw Mrs. McEwan, this time at the request of her husband's solicitors, and was called as a witness for the defence. In the course of his evidence he disclosed the facts learned and the opinion formed at his first examination, and one of these formed the alleged slander—viz., that the pursuer, being *enceinte*, and having left her husband's for her parents' residence, was desirous of terminating her pregnancy with the object of freeing herself from any reminder of her marriage. The action for separation failed, and in the sequel Mrs. McEwan and her father sued Sir Patrick Heron Watson for damages alleged to have resulted from his revelation in precognition and in the witness-box of information obtained while acting as her confidential agent and adviser. The defence was that the privilege of a witness was absolute as regards his utterances in court, and that similar protection extended to the precognition, as the written statement which a witness gives to a solicitor, and on which his evidence is based, is called in Scotland. The Court of Session decided that no action could lie as regards evidence, but allowed issues on the question whether the statements made as precognition were slanderous. Against this judgment Sir Patrick Heron Watson appealed, and the House of Lords reversed the decision of the Court below. The case for the appellant was that to limit the privilege of a witness to his evidence in open court, and to deny it to his preliminary statements made to solicitors and counsel, would be to render the protection illusory, since witnesses would decline to make statements to agents which might be actionable, while solicitors would hesitate to produce witnesses in ignorance of the precise evidence they were prepared to give. Mr. Haldane, for the defence, admitted that it was no part of his case to contend that statements made in the witness-box were actionable, nor even the taking of precognitions, but argued that a skilled witness was not entitled to impart the information acquired in his professional capacity to others than the parties who employed him. The Lord Chancellor gave his decison in favour of the appellant on the broad ground that the immunity of a witness in a law court was complete, and that not to extend the same immunity to statements made in precognition would hamper the administration of justice. That the decision of the House of Lords has been hailed with relief by the legal profession in Scotland may well be imagined, for the lot of a solicitor getting up a case, and met by a refusal of witnesses to give information which might prove actionable, would be none too happy; the esteemed President of the College of Surgeons may also be congratulated on being at last freed from the harassing worry of a long-drawn-out litigation. But the question of the professional secret seems more involved than ever. The Lord Chancellor in his judgment dismissed the matter as not arising in the condescendances, and we have only his conversation with Mr. Haldane to guide us as to his views. If A employs B to give his professional opinion with a view to legal proceedings, and if that opinion is against A's case, is B entitled to accept employment from A.'s opponent, and to divulge to him information obtained in his previous employment by A? The answer would seem obviously in the negative, yet the matter is less simple than appears at first sight. As the Lord Chancellor said, one side cannot appropriate a witness, while to Counsel's proposition that the informaton acquired by Sir Patrick Watson belonged to his client, and that he was not at liberty to disclose it to the other side, Lord Halsbury replied that after fifty-five years' experience he had never heard such a privilege claimed before. Mr. Haldane's contention was that under the circumstances it was Sir Patrick Watson's duty to decline to give the information either in the witness-box or precognition—and with this view many medical men would at first blush agree. But the crucial point in the matter is this: During Sir Patrick's evidence, in which he disclosed facts learned during confidential employment by Mrs. McEwan, no objection was raised on her behalf by her counsel, and by this acquiescence at the time they must be held to have deprived themselves of the right subsequently to dispute the propriety of utterances which were allowed to pass unprotested, and without any attempt to suppress them. It may freely be admitted that the position is not a very satisfactory one; fortunately it is not likely to recur, and the lesson to be drawn from it seems to be that a medical man who has acted as an expert adviser for a litigant, should decline under any circumstances, whether his opinion be favourable or not, to accept employment from the opposite party.

Correspondence.

GERMANY AND FRANCE.—THE PHYSIOLOGICAL BASIS OF NATIONAL STABILITY.

To the Editor of the Medical Press and Circular.

Sir,—In a recent leading article a prominent daily paper touched, although only casually, upon the dominant factor in the present relations between France and Germany. The following is the passage:—"Though the French army of to-day is far different from what it was then [in 1870], there is still a great disproportion between the resources of France and Germany. Germany, with a much larger population, can place a far stronger force in the field." The uneasiness of France in her present situation is dwelt upon by many public writers; but none of them discuss its prime cause. The uneasiness of France is due to the fact that since 1871 the population has remained stationary—about 38,000,000. This number is only kept up by immigration of Italians, Swiss, and Germans. France, with the most fertile soil—a soil capable of maintaining many more millions than at present subsist upon it—the most magnificent climate, and the most intelligent populace of Europe, has not enough men for her home requirements. She cannot spare, and virtually does not send, any emigrants to occupy and develop the vast possessions, misnamed colonies, which she has acquired mostly within late years; so that, on the whole, these have proved a useless burden upon, and source of weakness to, the State. It cannot be doubted that these territories will in time, either by peaceful or warlike conquest, be overrun by stronger and more prolific races. They may be even now the chief object of German covetousness. The population of Germany, which at the present rate of increase—the most rapid among the peoples of Western Europe—doubles itself in fifty years, stands now at upwards of 60,000,000; and the disparity between the two peoples will, of course, soon be much greater.

The causes of the stagnation of population in France are by no means hidden. They are understood not only by her men of science, but by every intelligent citizen. Children are few because parents are skilled in the art of preventing conception, and deliberately practise it. The dislike of a numerous progeny has its origin in the spirit of narrow anti-social egoism which has gradually grown until it permeates the great bulk of the race. Every higher aspiration is subordinated to the desire for a life of ease. Toil and self-sacrifice are regarded merely as the sources of pain and unhappiness. The number of children in families is governed by the fortune of the parents, but they very rarely indeed exceed three or four. Every girl has to be provided with a *dot* sufficient to attract a husband; every boy has to have an income assured, so that with a business to inherit, or a Government post gained, he may be safeguarded against the chance of poverty. The result is, that for every girl of the well-to-do class, unless she be a hopeless cripple in body or mind, a husband is found; for every man of the same class a wife—when not preferring mistresses—if he desire one. The stimulus to strive which comes from being thrown upon his own resources is very largely lacking to a Frenchman. He stays at home where the parents find an easy career for him; and he is too often brought up in a way that produces a want of the manly qualities which can be developed, as a rule, only in those who have to fight their own way in life. Besides thus restricting population, the French have been, for many years, carrying on what is, in fact, a gigantic system of artificial selection, ensuring to a large extent the survival of the least instead of the most fit. They are committing what has been styled "automatic race suicide." They are going to destruction owing to the same vices of civilisation that destroyed many nations of antiquity, but with the difference that they are going not blindly, but with eyes wide open and with a full view of the inevitable end. The main forces of evolution are as active to-day as in the old times, when the barbarian came down on decadent Rome. Dying nations will be replaced by the more virile, and the more quickly the more closely in contact they lie. In the case of France and Germany history is repeating itself. No prophet was needed to foretell what is now happening; it must have long been anticipated by serious students of contemporary history. Finally, let us bear in mind that we in these islands dare not look with pharisaical eyes upon the faults of our neighbours. We are following their example. Not only at home, but in the colonies, notably Australia, the birth-rate is declining, and there is no doubt about the cause. If this decline continues for a few years we shall be in a position similar to France. The expansion of the Empire will certainly be checked, and the first long step in its decline will have been made. As the weakness of France, rather than the strength of Germany, constitutes the danger near home, so the decadence of the Anglo-Saxon rather than the advance of the yellow races constitutes the peril to the wider world.

I am, Sir, yours truly,

Henry Sewill.

P.S.—A long despatch from Berlin appeared in the *Times* of July 13th, in which the able correspondent of that paper discusses the situation, the following significant passage occurs:—"With the cynicism and callousness which characterises German methods of dealing with concrete or abstract political problems, it is already being calculated upon the statistical basis of census returns that in process of time France will be outnumbered in point of population by Germany to such an extent that she will be compelled to abdicate her position as a colonial power in favour of her hungry and more prolific neighbour."

DR. WALSH'S CAP-FILM METHOD OF TREATING RINGWORMS.

To the Editor of The Medical Press and Circular.

Sir,—As a general practitioner I am truly grateful to hear of any method whereby ringworm of the scalp can be isolated and treated at the same time. Ringworm is common in the lower middle classes, and I can testify that I have found such cases a perfect bugbear. Treatment is carried out faithfully at first, but after a time the friends grow careless, and the case drags on month after month, or year after year in spite of every effort on the part of the medical attendant. Dr. Walsh's method of scalp isolation is simplicity itself, and if it cures as well as isolates, it will indeed be a god-send to yours truly,

A General Practitioner.

Dulwich, August 10th, 1905.

STRAPPING THE CHEST IN TUBERCULOUS DISEASE.

To the Editor of The Medical Press and Circular.

Sir,—Some thirty years ago, Dr. McCree, of Belfast, published an article in The Medical Press and Circular about strapping the chest in tuberculous disease when confined to the upper lobes of the lung. I several times have found great benefit from it. I lately had two cases of disease of the right lung in females. Both of them were spitting some 12 ozs. or more daily; one had also night sweats, and at the time seemed almost a hopeless case. The case, though it was last March and the weather was cold and damp, rapidly improved; she is now almost well, and expectorates very little at all.

The other case improved very much, and the expectoration diminished to one-fourth. Unfortunately she has Bright's disease very far advanced, so her case is hopeless.

The plaister must be carried over the shoulders, well down back and front, and cross-straps under the armpits and sides of chest. This must be done carefully, so as to practically close the chest and chest movements as much as possible. Unless done every fourteen or twenty-one days they are useless, as they get loose and troublesome. Both patients sent me word to do it again when loose, as they said it gave them great relief.. I also advised them to use the arm of the side affected as little as possible.

My excuse for troubling you with this communication is that any remedy that helps towards a cure should not be neglected, and I know from personal experience that constant coughing up matter is one of the things that wear out a patient.

I am, Sir, yours truly,

Charles B. Stoney, M.B., M.Ch.

Diss, August 9th, 1905.

The International Congress of Anatomy has arranged a meeting at Boston in 1907.

Poison given for Medicine.

The death under distressing circumstances is reported of the little daughter of Mr. Oliver, head gardener to Sir Mountstuart Grant Duff, of Lexden Park, Essex. The child had suffered from whooping-cough, and her mother, on being suddenly roused from sleep, by a mistake gave the child a poisonous lotion intended only for outward application.

Obituary.

CHRISTOPHER HEATH, F.R.C.S.Eng., LL.D. Mont.

The death of this gentleman, which occurred suddenly last week at his residence in Cavendish Square, London, will be viewed generally as a great professional loss. Few names are better or more widely known in the ranks of brilliant surgeons than that of Christopher Heath, who was Emeritus Professor of Clinical Surgery in University College, London; Consulting Surgeon to University College Hospital, and a former President; Hunterian Orator, Bradshaw Lecturer, and Examiner of the Royal College of Surgeons of England. He was born in 1835, being the son of Mr. Christopher Heath, of Gordon Square, and grandson of Mr. John Heath, R.N., who served in Lord Howe's flagship more than a century ago. Mr. Heath was educated at King's College School, and in his early days at King's College Hospital he was much associated with Sir William Ferguson; he was for a few years assistant surgeon and lecturer on anatomy at Westminster Hospital, where he wrote his "Practical Anatomy," which ran through eight editions. In 1866, he was appointed assistant surgeon to University College Hospital. In 1867 he was awarded the Jacksonian Prize of the Royal College of Surgeons for his essay on "Injuries and Diseases of the Jaws," which became the standard work on that subject in the English language. His "Course of Operative Surgery" gives a concise exposition of the operations performed under his direction as teacher of operative surgery. In 1871 he became surgeon to the hospital, and on Sir John Erichsen's retirement in 1875 Holme Professor of Clinical Surgery. The conciseness and clearness with which he lectured is well illustrated by his "Clinical Lectures on Surgical Subjects." He devoted himself to the task of impressing upon students the important features of common surgical affections and of ascertaining by question and answer that each student grasped these essential features. Mr. Heath's manual of "Minor Surgery" has passed through no fewer than twelve editions. His "Dictionary of Practical Surgery" and his "Students' Guide to Surgical Diagnosis" are both well-known works. At the Royal College of Surgeons, Mr. Heath filled all the important positions. In 1875 he became a member of the Board of Examiners in Anatomy and Physiology, in 1883 a member of the Court of Examiners in Surgery. He had already in 1881 been elected a member of the council of the college, and in 1895 he became president. In 1897, Mr. Heath was invited to deliver the second course of Lane Medical Lectures in connection with the Cooper Medical College in San Francisco, and the University of Montreal seized the opportunity of his presence on the American Continent to confer upon him the degree of LL.D. He leaves a widow and five sons and one daughter. In Mr. Christopher Heath the medical profession has lost a distinguished ornament. Not only was he a bold and brilliant operator, but he had the great gift of teaching. No great surgeon of his generation had a finer record as a teacher, and his fame in that direction attracted many students to University College.

JOHN WILLIAM OGLE, M.A., M.D., F.R.C.P.

Last week an old and much esteemed practitioner, Dr. John William Ogle, Consulting Physician to the St. George's Hospital, died at the Vicarage, Highgate, at the age of 81. He graduated M.D. in 1857 and F.R.C.P. in 1855, and was Vice-President of the Royal Med. Chir. Soc. in 1885. Dr. Ogle had a long connection as lecturer and examiner at St. George's Hospital, and contributed many valuable articles to the leading medical journals. By his death we lose one of the best-known men, who united wide culture to the knowledge more immediately connected with his profession.

Literature.

THE INFLUENCE OF GROWTH ON CONGENITAL AND ACQUIRED DEFORMITIES. (a)

This book from the pen of an American writer is very much like many which have preceded it on the same subject.

The author states in his introduction that he ventures to present to the reader a new volume on orthopædic subjects, not because there is any lack of excellent systems and text-books, but rather to emphasise what seems to him to be at the base of practice in this specialty, the fact that prevention and cure are to be found in so managing a case and equipping a patient that natural growth will be the principal factor in recovery. He then goes on to quote Hilton's remark that repair is but the repetition of growth. The same elements, the same kindred conditions, are necessary to the same results.

The treatise is divided into ten chapters, which include the subjects of Club Foot, Deformities caused by Infantile Paralysis, Tubercular Joint Disease, Hip Disease, Angular and Lateral Curvature of the Spine. There is nothing very new in the book, but like many others of the same kind it is plain, practical, and readable.

A SYSTEM OF CLINICAL MEDICINE. (b)

It is obvious that in writing on clinical medicine the author ought to approach the subject of disease as it presents itself to us at the bedside. Inquiry elicits certain signs and symptoms and we have to decide this probable cause. To do this we must pass in review all the possible causes, and we must have before us a mental table of the morbid conditions of which the actual symptoms may be the manifestations. It is the merit of the author of the System to have realised the importance of this method of imparting a knowledge of disease and to have applied it *seriatim*. The method is even more essential to students than to practitioners, inasmuch as it trains them how to reason on the basis of their own observations. It is indeed the method adopted by all the great clinical teachers of modern times, whose principles the author has embodied in these 1,100 pages of text—viz., to proceed from symptoms and signs to diagnosis, prognosis, and treatment.

The student preparing for examination will find this work specially useful in that it provides him with exactly the kind of information for which examiners yearn. Suppose he is shown a case in which albumin is present in the urine, obviously he will be asked what is the probable cause of the leakage. We turn to "Albuminuria," and we find a schedule of the morbid conditions that have this symptom in common, and incidentally it is explained how we are to differentiate between them. This is precisely what the ordinary text-book on medicine fails to do.

The method is equally useful in respect of treatment, for after all, treatment is mainly symptomatic only that the particular symptom has to be dealt with somewhat differently according to its probable cause. Here again, in ordinary text-books, the student is taught how to treat disease, as if a disease were an entity, instead of, as it is, a concatenation of symptoms.

Yet another advantage accrues, as the author points out, to the young observer from this process of balancing evidence and comparing diseases. It not only impresses facts upon the memory, but it constitutes one of the best possible means of training him to habits of accurate and complete observation, and of systematic and productive thought; his faculty of systematising his knowledge is gradually increased and his reasoning powers strengthened and corrected. He finds that without accuracy in respect of the most minute details he may be led astray by the more important ones, that without system in the marshalling of his facts, he will not be able to apportion the proper significance and importance of each, thus incurring the risk of arriving at erroneous conclusions, based though they may be on correct premises and facts.

(a) "The Influence of Growth on Congenital and Acquired Deformities." By Adoniram Brown Judson, A.M., M.D., Orthopædic Surgeon to the Out-Patient Department, New York Hospital. Illustrations 134, pp 276. New York: William Wood and Co., 1905.

(b) A System of Clinical Medicine." By Thomas D. Savill, M.D.Lond., Physician to the West-end Hospital for Diseases of the Nervous System, and St. John's Hospital for Diseases of the Skin, &c., &c. In two volumes. London: J. and A. Churchill. Price, 12s. 6d. net.

Although we have insisted more particularly on the value of a work of this kind for students, it is hardly necessary to state that the non-application of this closely reasoned method is at the root of most of the errors imputed to general practitioners. Busy practice creates a tendency to deal with symptoms at first hand, without stopping to inquire of what they are symptomatic. If the practitioner jumps too hastily at a diagnosis of tonsillitis, for example, he will certainly overlook cases of diphtheria, syphilis, and even scarlet fever, and this remark applies to all leading symptoms.

The work is provided with illustrations and diagrams where necessary to the elucidation of the text, and there are useful dietetic tables and therapeutical formulæ. The author is to be congratulated on having satisfactorily accomplished his self-imposed task and no doubt, in future editions, he will still further elaborate the method in regard to details.

DISEASES OF THE STOMACH AND INTESTINES.

It is a pleasure to be able to give praise to the literary work of an American colleague, and to Dr. Boardman Reed's "Lectures on Diseases of the Stomach and Intestines" (*a*) we can do so unreservedly. There are but two books on this side of the Atlantic with which it can be compared for knowledge of subject, completeness and lucidity, and besides these books it takes its stand as an authoritative exposition of all that is well founded, durable, and trustworthy in modern methods and modern science, in connection with diseases of the gastro-intestinal tract. If we have a criticism to offer it is that the lectures on the stomach are fuller and more exhaustive than those of the lower part of the alimentary tract, but we presume that this is so because Dr. Reed is brought into more frequent personal contact with sufferers from gastric troubles than with those whose maladies are situated in the intestines. We make this presumption because personal experience is the key-note of the volume. Scissors and paste are conspicuous by their absence, though due recognition is given to the work of others in their appropriate spheres. As we read we feel we are walking side by side with a practical physician who is a physician first, a scientist next, and a student most of all. Then, Dr. Boardman Reed has been happy in the choice of lecture-form in which to present his knowledge to us. Though never undignified, he is affable, easy, charming, he knows exactly where our difficulties lie, he knows how to anticipate and circumvent them. He tells us how, in simple, colloquial, straightforward style. There is no assumption of superiority; all are learners, and he is merely telling us how he learned; nothing is taken for granted. If we want to coax a stomach-tube down a refractory patient's gullet, he relates his own method of doing so; if we forget where McBurney's point is, he mentions it as a necessary detail; if we are unacquainted with the method of applying intra-gastric faradaism, he shows how it is done. Full of information to the general physician or "specialist," the book is essentially one for the general practitioner, who can but feel grateful to the author for having coached him so carefully through all the complications that beset the present study of gastric disorders. But though devoting himself to a special study, Dr. Reed never forgets that he is a physician. In Lecture XXII., which he gives as a preliminary to description of the various therapeutic procedures that may be undertaken in diseases of the stomach, he emphasises most strongly the dangers of reliance on this, that, or the other method. "Many failures in treatment," he writes, "occur in cases in which the physician has made a correct diagnosis, but places too little stress in his directions to the patient upon the importance of changing radically the faulty modes of living which produced the disease. Unless we stop the leak, however, which is draining away the energies of the patient, we shall make little permanent progress in curing him, whether we rely chiefly upon hydrotherapy, massage, or other manual treatments, electricity, vibratory stimulation, climatotherapy, or merely upon the most skilfully concocted combinations of medicine." This is the spirit in which a treatise on a particular part of the body should be animated—a well-balanced, well-proportioned conception of the patient as a sick man, not a mere *corpus vile* for the practice of special methods. In discussing treatment, Dr. Reed is as good as in describing methods of examination, and much is to be learned from his statements of facts that he has verified himself. For instance, in speaking of the use of alkalies in stomach affections, he contradicts emphatically the oft-repeated statement that alkalies before meals increase the secretion of HCl, whilst after meals they diminish it. small doses of alkalies always increase, and large doses always diminish acidity. The failure to neutralise acidity often lies in the fact that 10 to 15 grains of bicarbonate are given instead of much larger doses. This Dr. Reed has often confirmed in practice. The whole book is full of accurate information, practical hints, and sound thinking.

CLEFT PALATE AND HARELIP. (*a*)

The chief object of Mr. Edmund Owen's interesting little monograph is evidently, as he himself says, to bring into more general notice the excellent work which has been accomplished in the treatment of cleft palate by Dr. Tauman Brophy, the President of the Chicago College of Dental Surgery. Dr. Brophy's method in operating on the cleft palate in infants consists, after paring the edges of the cleft and passing silver sutures through the substance of the maxillæ, in squeezing the maxillæ together; this being facilitated by incising the mucous membrane over each malar process, and dividing the maxillæ sufficiently to enable their palatine process to be thrust into the middle line. Although Mr. Owen says in his preface that he hopes young surgeons may find help in the pages of this little book in overcoming the difficulties of operations on cleft palate, the explanation of the operation by Dr. Brophy's method would not, we think, be of as much service to the neophyte as to the surgeon skilled in operations on the palate; but on the other hand the descriptions of the operation undertaken after infancy is very lucid, and the chapters on the preparation of the patient and on the care of the child after operation are very practical and instructive. The chapter on the operation for harelip is very interesting. In fact, the whole book teems with hints that should be of great value to every practical surgeon.

THE SEWAGE PROBLEM. (*b*)

This book is a brief digest of fourteen volumes containing the evidence and the accompanying reports by the officers of the Royal Commission on Sewage Disposal, in which the compiler deals with the more important evidence on some of the practical points. He has also drawn "to a limited extent upon outside sources for information which seemed to throw light on the matters under consideration." The writer has

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(*a*) "Lectures on Diseases of the Stomach and Intestines. for Practitioners and Students." By Boardman Reed, M.D., Professor of Diseases of the Gastro-Intestinal Tract, Temple College, Philadelphia. Bristol: J. Wright and Co., 1905. 21s. net.

(*a*) "Cleft Palate and Hare Lip." (Medical Monograph Series.) By Edmund Owen, M.B., F.R.C.S. Pp. 103. London: Bailliere, Tindall and Cox.

(*b*) "A Review of the Evidence Collected by the Royal Commission on Sewage Disposal." By Arthur J. Martin, Assoc.M.Inst.C.E., M.R.San.I. Price 8s. 6d. net. 1905. Pp. 363—xvi. London: The Sanitary Publishing Company, Ltd.

endeavoured "to indicate the general trend of the Commissioners' investigations, and to bring together in a concise form, some of the evidence which they have collected with regard to certain practical questions, the information concerning which has hitherto been both scanty and disconnected."

To anyone who is likely to have occasion to refer to this subject, we heartily commend this volume, compiled as it is, by one who is capable of appreciating the relative values of the opinions of those gentlemen who had the honour of giving evidence before the Commission, and whose knowledge of the subject is so great as to allow him to judge with accuracy where it would be advisable to supplement the evidence, with information from other sources, and remarks on the subject based on his own experience. It would greatly benefit the scientific world if experts in other branches of science, would lay us under obligations similar to those Mr. Martin has imposed on us, with regard to other Royal Commissions. Such works edited by capable men, would be much more widely read and better appreciated than the bulky volumes issued under the auspices of his Majesty's Government.

NEW BOOKS AND EDITIONS.

The following have been received since the publication of our last list :—

The Aberdeen University Press, Ltd. (Aberdeen).
  The Royal Medical and Chirurgical Society of London. Centenary 1805-1905. By Norman Moore, M.D., etc., and Stephen Paget, F.R.C.S. Pp. 337.

Bailliere, Tindall and Cox (London).
  The Diagnosis of the Diseases of Women. By Palmer Findlay, B.S., M.D. Second Edition. Revised and Enlarged. Illustrated. Pp. 588. Price 21s. net.
  A Handbook of Intestinal Surgery. By Leonard A. Bidwell, F.R.C.S., Illustrated. Pp. 167. Price 6s. net.
  Carcinoma of the Rectum. By F. Swinford Edwards, F.R.C.S. Pp. 47. Price 2s. 6d. net.

Cassell and Co., Ltd. (London).
  The Care and Management of Delicate Children. By Dr. Percy Lewis. Pp. 192. Price 3s. 6d.

Messrs. J. and A. Churchill (London).
  On the Hours of Sleep at Public Schools. By T. D. Acland, M.A., M.D., etc. Pp. 33. Price 1s.

Wm. Green and Sons (Edinburgh).
  A Contribution to the Pathology of the Endometrium. By Jessie M. Macgregor, L.R.C.P. & S., M.D. Illustrated. Pp. 52.

Charles Griffin and Co., Ltd. (London).
  An Introduction to Midwifery: A Handbook for Medical Students and Midwives. By Archibald Donald, M.A., M.D., etc. Sixth Edition. Illustrated. Pp. 192. Price 5s.

Homœopathic Publishing Co. (London).
  Homœopathy Explained. By J. H. Clarke, M.D. Pp. 212. Price 2s. net.

H. K. Lewis (London).
  The Child's Diet. By J. Sadler Curgenven, M.R.C.S., L.R.C.P. Pp. 96. Price 1s. 6d. net.
  A Synopsis of the Principal Changes in the United States Pharmacopœia. By W. Harrison Martindale, Ph.D. Pp. 36. Price 2s.

Young J. Pentland (Edinburgh).
  The Edinburgh Medical Journal. New Series. Vol. XVII. Edited by G. A. Gibson, M.D., F.R.C.P., A. Thomson, M.D., F.R.C.S., and H. Littlejohn, M.B. Pp. 616.

The Scientific Press, Ltd. (London).
  A Practical Guide to Cookery in West Africa and the Tropics. By Sister Cockburn. Pp. 160. Price 3s. net.

W. B. Saunders and Co. (Philadelphia).
  Dietetics for Nurses. By Julius Friedenwald, M.D., and John Rubrah, M.D.
  A Text-Book on the Practice of Gynæcology. By W. Easterly Ashton, M.D., LL.D.
  Atlas and Text-Book of Topographic and Applied Anatomy. By Prof. D. O. Schultze. Edited by G. D. Stewart, M.D.
  Malarial Diseases, Influenza and Dengue. By Dr. S. Mannaberg and Dr. O. Leichtenstern. Edited by Ronald Ross, F.R.C.S., etc., etc., J. W. W. Stevens, M.D., and Alfred Grunbaum, F.R.C.S.
  The Vermiform Appendix and its Diseases. By Howard A. Kelly, M.D., and E. Hurdon, M.D.
  Atlas and Epitome of Operative Ophthalmology. By Dr. O. Haab. Edited by G. E. de Schweinitz, M.D.

A. Siegle (London).
  Electrical Methods in the Treatment of Affections of the Stomach and Intestines. By George Herschell, M.D. Pp. 108. Price 3s. 6d. net.

Spottiswoode and Co., Ltd. (London).
  Minutes of the General Medical Council and of its Various Committees from Jan. 1st, 1905, to May 27th, 1905. With seven Appendices. Vol. XLII. Pp. 294.

John Wright and Co. (Bristol).
  Natural Science in Hygiene. By J. R. Watson, M.A., M.D. Pp. 62. Price 1s. 6d.
  Disorders of Metabolism and Nutrition. Vol. VI. Drink Restrictions. By Prof. Dr. Carl von Noorden and Dr. Hugo Salmon. Pp. 86. Price 3s. net.

Medical News.

Fatal Accident to a Medical Man.

We regret to announce the death of Mr. John Auterson, a well-known medical practitioner residing at Cookstown, co. Tyrone. Mr. Auterson was paying a professional visit on the night of August 5th, when his horse shied at a reflected light, and backed over the edge of the road, which at this point is quite unprotected. In consequence, trap and occupier were precipitated into a bog some fifteen feet below. Fortunately the accident was seen by a neighbour, and Mr. Auterson was removed to a neighbouring house, where he was attended by his professional confreres. On the evening of the following day he was removed to his own house, but he never rallied, and died on August 7th, the following day. Mr. Auterson became qualified in 1868, and thirty years ago he settled in Cookstown, where he had built up a large practice. He was unmarried.

Tuberculosis Commission.

The President of the Local Government Board has informed Mr. Reginald Lucas, M.P., that it is not possible to say at present when the final report of the Royal Commission on Tuberculosis will be issued, but that the Commission hope to make an interim report towards the end of the present year.

Memorial to Jenner.

In connection with the indication by the London County Council of houses in London which have been the residences of distinguished individuals, a memorial tablet was erected last week on No. 14, Hertford Street, Park Lane, where Edward Jenner, the originator of vaccination, resided in 1803. It bears the following inscription: "Edward Jenner, 1749—1823, Originator of Vaccination, lived here."

The Dublin Horse Show.

We have been informed that there is a rumour in London that, owing to an outbreak of epigastric lymphangitis in parts of Ireland, the Horse Show held annually by the Royal Dublin Society, and commonly known as the Great Irish Horse Show, is to be abandoned this year. There is, however, no truth in this rumour. The show will open on the date originally announced, August 22nd, and will be even larger than that of last year. There are 1,222 entries representing 1,156 horses; in 1904 there were 1,219 entries, representing 1,150 horses, this too, in spite of the fact that all entries from infected districts have necessarily been refused.

PASS LISTS.

The Triple Medical Qualification.

At the July sittings of the Scottish Conjoint Board of the Royal Colleges of Physicians and Surgeons of Edinburgh and Faculty of Physicians and Surgeons of Glasgow, held in Glasgow, the following candidates passed the respective examinations :—

First Examination (*five years' course*).—Robert H. Jones, Denis Cogan, Thomas S. Douglas, Jehangir C. Balsara, William G. H. Brooks, Robert S. Watt, Phiroza Malabari, Daniel Murphy.

Second Examination (*five years' course.*)—Matthew H. Fleming, Walter Riddell, George L. Irwin, Alexander P. Dias, Abraham D. Woolf.

Second Examination (*four years' course*).—George M. Macleod.

Third Examination.—Hugh G. Anderson, James Logan, John Dawson, Andrew Baxter, Alexander Dick, John A. Smith, Kenneth J. Logan.

Final Examination (*and admitted Licentiate of the three co-operating authorities*).—William N. Walker, William W. Dempster, William P. Timmon, Whitfield de Witt Henty, Joseph Owens, John MacNamara, Lorris E. Borden, William N. Alexander, Herbert M'Master, Jehangir C. Balsara, Julius E. Streeter, John P. Newton, Jesudasan S. Lamsch, James Taylor, (with honours): Alexander Dick, John G. Heathcote.

Notices to Correspondents, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

A. H. (Newark).—You will find an article on the treatment of stiff and contracted joints by air pressure in the *Munchener Med. Wochenschrift* No. 17, 1905. Klapp and Bier claim that by means of the passive hyperæmia induced during the operation, absorption of the inflammatory exudation is stimulated.

REVENUE FROM THE SALE OF PATENT MEDICINE STAMPS.

WE fear it would need a very bold Chancellor of the Exchequer to do away with the abomination known as the "Patent Medicine Stamp," when it yields to the Public Revenue the astounding sum of £331,439, the amount realised for the twelve months ending March last. This is an increase of £8,000 on the previous year, and nearly £100,000 more than it was a decade ago, strong presumptive evidence, were such needed of the enormous extent to which self-medication has attained.

DR. D. (Stirling).—Recurrent temporary amblyopia is probably a vaso-motor affection. It may depend on malaria. In any case it would be well to seek the advice of an ophthalmic surgeon.

HOSPITAL.—The application of the microscope to the study of food and drugs can hardly be said to be of recent date, seeing it was seriously made by Dr. A. H. Hassall about the middle of the last century. His work in adulteration is classical and famous as well as monumental.

ANALYST (St. Ives).—The only method we know of detecting sawdust in bread is to spread out the flour in a thin layer and moisten it with a 0·2 p.c. aqueous solution of paraphenylenediamine. On adding acetic acid the woody fragments assume an orange red colour while bran particles are unaffected. There is believed to be a good deal of adulteration in bread even in the present days of cheap flour.

X-RAYS (Cork).—The Röntgen Society in celebrating their 10th anniversary in Nov. 1905 are asking members to send in specimens of early work. They would doubtless be glad to see the radiograms you mention.

Meetings of the Societies, Lectures, &c.

MONDAY, AUGUST 14th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. Davis: Medical Cases.

TUESDAY, AUGUST 15th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Bidwell: Surgical Treatment of Ascites.

WEDNESDAY, AUGUST 16th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Dunn: Tobacco Amblyopia.

THURSDAY, AUGUST 17th.

POST-GRADUATE COLLEGE West London Hospital, Hammersmith Road, W.).—4 p.m. Mr. Edwards: Surgical Cases.

FRIDAY, AUGUST 14th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Common Symptoms of Throat, Nose, and Ear Diseases.

Vacancies.

Noble's Isle of Man Hospital and Dispensary, Douglas, Isle of Man.—Resident House Surgeon. Salary £90 a year, with board and washing. Applications to Richd. D. Gelling, Honorary Secretary, St. George's Chambers, Athol Street, Douglas, Isle of Man.

Royal South Hants and Southampton Hospital.—House Physician. Salary £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher-Hall, Secretary.

Royal Victoria Hospital, Bournemouth.—A House Surgeon. Salary £100 per annum, with board and lodging. Applications to the Secretary.

Exeter City Asylum.—Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Digbys, Exeter.

Essex and Colchester General Hospital.—House Surgeon, Salary £100 per annum, with board, washing and residence in the Hospital. Applications to Alfred G. Buck, Secretary, The Hospital, Colchester.

Metropolitan Water Board.—Laboratory Assistants.—
A Senior Chemical Assistant. Salary £300 per annum.
A Senior Bacteriological Assistant. Salary £300 per annum.
A Junior Chemical Assistant Salary £175 per annum.
A Junior Bacteriological Assistant. Salary £175 per annum.
Two Laboratory Assistants. Salary £75 each per annum.
Applications to A. B. Pilling, Clerk of the Board, Savoy Court, Strand, W.C.

Parish of Saint Leonard, Shoreditch—Second Assistant Medical Officer.—Salary £100 per annum, with rations, washing, and furnished apartments in the Infirmary. Applications to Robert Clay, Clerk to the Guardians, Clerk's Office, 2 3 Kingsland Road, N.E.

Manchester Children's Hospital, Pendlebury, near Manchester.—Junior Resident Medical Officer. Salary £80 per annum, with board and lodging. Applications to the Secretary, the Hospital, Pendlebury.

Appointments.

BLUMFELD, J., M.D.Cantab., Honorary Anæsthetist to St. Mary's Hospital, Paddington, W.

BONNEY, VICTOR, M.S., M.D., B.Sc.Lond., F.R.C.S., M.R.C.P., Emden Research Scholar to the Cancer Investigation Department of the Middlesex Hospital.

BUSHNELL, F. G., M.D.Lond., Vice-president of the Devon and Cornwall Sanatorium for Consumptive Poor.

ECKERSLEY, EDWARD AUTHUR, M.B., C.M., Clinical Assistant to the Hospital for Diseases of the Skin, Blackfrairs, S.E.

EVANS, THOMAS, M.D., Clinical Assistant to the Hospital for Diseases of the Skin, Blackfriars, S.E.

FIELDEN, E. M.B., M.S.Durh., Certifying Surgeon under the Factory and Workshop Act for the Bracknell District of the county of Berks.

GOLDIE, E. M., M.D.Edin., Visiting Surgeon to the Royal Merchant Seamen's Orphanage, Snaresbrook.

Births.

ALEXANDER.—At Stalbridge, Dorset, the wife of W. G. Alexander, M.B., C.M.Edin., of a daughter.

BENNETT.—On August 10th, the wife of William Fay Bennett, M.R.C.S., L.R.C.P., of Barrow, near Bury St. Edmunds, of a daughter.

FENWICK.—On August 10th, at 29 Harley Street, London, the wife of W. Soltau Fenwick, M.D., of a son.

SANKEY.—On August 7th, at 25 South Quay, Great Yarmouth, the wife of J. Ivor Sankey, M.R.C.S., L.R.C.P., of a daughter.

WILLIAMS.—On August 10th, at Abbotsfield, Slough, Bucks, the wife of Ralph Paul Williams, M.D.Lond., of a son.

Marriages.

GARSTANG—VON MOLLIN.—On August 9th, at the Parish Church, Steep, Petersfield, Thomas James Garstang, M.A., of Bedales School, second son of the late Walter Garstang, M.D., of Blackburn, to Ilsa, only daughter of the late Alfred Eric von Mollin, of Helsingfors, Finland, and of Agnes von Mollin, Petersfield.

OPERATIONS—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopædic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9 30 a.m. and 2.30 p.m.), Gt Ormond Street, 9 30 a m.), Gt. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p m), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynæcological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p m.), Throat, Golden Spuare (9.30 a.m.), City Orthopædic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St George's (1 p.m), St. Mary's (10 p.m.) Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.35 p.m.), Middlesex (1.30 p.m), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynæcological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopædic (2 p.m.), City Orthopædic (4 p.m.), Great Northern Centre (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.) Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).

PRACTICE.—Wanted to Purchase a small practice, near Dublin. Sea-side preferred.- Reply to S. B. care of MEDICAL PRESS AND CIRCULAR, 16 Lincoln Place, Dublin.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, AUGUST 23, 1905. No. 8.

Original Communications.

OCULAR THERAPEUTICS. (a)

By SYDNEY STEPHENSON, M.B., F.R.C.S.E.

(*Continued from Page* 162.)

LECTURE III.

5.—MISCELLANEOUS REMEDIES.

Supra-renal Extract.—In 1896, Dr. Bates, of New York, familiarised surgeons with the effects of an extract of suprarenal capsule upon the eye by showing that a 1 per cent. solution acted simply and solely as a powerful vaso-constrictor. The observation was not taken up widely, mainly because the suprarenal was difficult to procure and not easy to keep in an active state. Still, the experiments that were made confirmed Dr. Bates' main assertions. Since then, as everybody knows, adrenaline chloride has been introduced by Dr. Takamine, and placed upon the market by Messrs. Parke, Davis, and Co., thus giving us a most convenient, cleanly, and active preparation of suprarenal body. More recently still, three substitutes, namely, "renoform," "hemisine," and "paranephrin," have been introduced as cheap and convenient substitutes for adrenaline. "Renoform" is a fluid extract of the active principle of the suprarenal bodies, manufactured by a Berlin firm of chemists. Goldschmidt (*Die Therapie der Gegenwart*, July, 1903) recommends it as an economical, active, and non-irritating substitute for adrenaline, which, truth to tell, is somewhat costly. "Hemisine," one of Messrs. Burroughs Wellcome and Co.'s preparations, is described as "a derivative of the suprarenal gland, and is put up in ophthalmic tabloids, each of which contains approximately 1-100th of a grain." One of these tiny tabloids dissolved in 10 minims of water forms a solution of 1 in 1,000. I can testify to the fact that "hemisine" is an active preparation. "Paranephrin," a new product of the Darmstadt firm of Merck, is a stable 1 : 1,000 solution of paranephrin in 0·6 per cent. solution of common salt. Polte (*Archiv für Augenheilkunde*, November, 1904) has made careful experimental trials of the product, the action of which is that of suprarenal extracts in general.

From what has been said it will be obvious that we are now in possession of several trustworthy suprarenal preparations, British and foreign.

When a physiologically active preparation of suprarenal gland is dropped into the conjunctival sac, the mucous membrane becomes markedly blanched in the course of a few moments. As regards its whiteness, the eye may be said almost to resemble an artificial eye in appearance. There is no action upon the pupil, the accommodation, or, indeed, upon any other structure or function of the eye. The anæmic condition lasts for about an hour, more or less. The knowledge of this property of adrenaline has spread beyond the members of the medical profession. It appears that trachomatous immigrants seeking admission to the United States have endeavoured to turn the vaso-constrictor powers of adrenaline to good purposes in concealing their disease. They have found that all evidences of mild trachoma can be obliterated for about half an hour if adrenaline be dropped into the eyes. However, the inspectors have been equal to the occasion, and now make not one but several examinations of suspicious cases.

It was at first thought that the intense vaso-constrictor action of adrenaline might be turned to advantage in the treatment of superficial diseases of the eye, and many trials in that direction have been made. But as Dr. J. A. Menzies has well said (*Ophthalmoscope*, Vol. II., 1904, p. 500), "congestion is Nature's attempt to remove the cause of a conjunctivitis by a free flushing with blood and lymph. To use adrenaline in such a case, without at the same time attacking the disease, is to thwart Nature's attempt at cure without introducing an alternative attempt. . . . The use of adrenaline in such a case is, therefore, a confession of helpless ignorance." In short, accumulated experience now shows that the main use of adrenaline must be sought in directions other than the relief of actual disease. The agent, it is true, does exert a beneficial effect upon a conjunctival disease, rare in England, Spring catarrh, but common enough in some other countries. At the same time, in my experience, it is not a specific even in that disorder. In glaucoma, also, adrenaline is certainly not devoid of power. Grandclément (*La Clinique Ophtalmologique*, 1904) has insisted upon the fact that it is capable of curing glaucoma without operation, provided the disease has not lasted long enough to produce organic tissue changes, and, further, that the drug, combined with physostigmine, be used very frequently—say every half-hour for several days. The same author (*Die Ophthal. Klinik*, August 20th, 1904) has improved sight in a case of buphthalmos—that is, congenital glaucoma—by using the following collyrium: eserine, 0·50; adrenaline, 1 : 1,000, 3; distilled water to 10·0. At the same time, it must not be forgotten that Mr. A. F. MacCallan (*Trans. Ophthalmological Society*, Vol. XXIII., 1903) has reported five cases of glaucoma in which adrenaline caused an increase in tension, an observation more recently confirmed in two cases of glaucoma by Dr. A. Senn (*Woch. f. Therapie u. Hygiene des Auges*, 1905). The result is, however, very unusual, and it would be unfair, as MacCallan himself admits, to lay undue stress upon the fact.

For my own part, I have never seen anything but benefit result from the addition of adrenaline to physostigmine in the medicamentous treatment of chronic glaucoma. The prescription I usually give combines ¼ grain of the sulphate of physostigmine with 4 drachms of a 1 : 2,000 solution of adrenaline chloride, and, if pain be a prominent feature, as stated before, five grains or more of dionine are added to the liquid.

The fact should be mentioned that the reckless employment of adrenaline has been known to produce failure of sight and softness of the eyeball, the latter lasting, as in Grandclément's case, for several months (*Die Ophthal. Klinik*, August 20th, 1904).

(a) Lectures delivered June, 1905, at the Polyclinic London.

There are three other uses to which adrenaline or its substitutes may be put—(1) to prevent hæmorrhage during operations upon the eye; (2) to assist in the absorption of other remedies; and (3) to aid in the diagnosis of certain diseased conditions of the eye.

(1) With respect to the first of these uses, the prescription may stand: cocaine hydrochloride, 2 per cent. dissolved in adrenaline hydrochloride, 1 : 2,000; a drop into the eye every two minutes for six or eight minutes before operation. Cohn (*Woch. f. Therapie u. Hygiene des Auges*, November 24th, 1904) has experimented with a new combination of cocaine and adrenaline, which goes under the name of "eusemin." It contains, in addition to the two alkaloids mentioned, chloretone and physiological salt solution. It is most useful as a local anæsthetic in eye operations, and may be injected beneath the skin or the conjunctiva. There can be no doubt that when operating for squint, adrenaline does render the parts more or less bloodless, and in that way simplifies the operation, an important point, more especially if my plan of lengthening instead of dividing the tendon be adopted. For iridectomy and cataract, however, the preliminary vaso-constriction may be followed by reactionary bleeding into the anterior chamber, as happened to me in four successive iridectomies. Since that experience I have used adrenaline less frequently as a hæmostatic than I did formerly.

(2) With respect to the second use of adrenaline, namely, of helping the absorption of other remedies, it is a fact that when the eyeball is markedly reddened, as in acute iritis, atropine will act better upon the pupil if combined with adrenaline than if employed alone. But, according to Dr. R. Mengelburg (*Woch. f. Therapie u. Hygiene des Auges*, No. 32, 1903) there is a danger in that very fact, since symptoms of atropine poisoning are apt to be set up. It is thought that the lumen of the lacrymal passages is widened by constriction of the vessels, so that the passage of atropine from the conjunctival sac into the nose and throat is thereby facilitated. Again, in using fluorescein for the staining of raw spots on the cornea, the preliminary drop of cocaine or of adrenaline will render the process of colouration quicker and more complete. In the passage of a lacrymal probe, too, adrenaline by acting as an astringent to the mucous membrane, is often of service.

(3) As to the third point, by applying adrenaline to an inflamed eye, the distinction between conjunctival and ciliary redness may often be established in a very conclusive and pretty way, since the conjunctival system is alone affected by a single drop of the medicament.

Jequiritol.—This agent, introduced by Römer, of Würzburg, represents, as Dr. Albert B. Hale (*loco citato*) has well said "the application of the modern laboratory idea to botanic as well as to therapeutic science." Jequiritol is a standardised abrin preparation obtained from the seeds of the *Abrus precatorius*, and intended to be a scientific and exact substitute for the older jequirity solutions, which in their turn replaced the ancient inoculation of an eye with gonorrhœal pus. It is supplied in four different strengths, with a curative serum and printed instructions for use in a wooden box by Merck, of Darmstadt. No. 1 concentration is the mildest, and No. 4 is the strongest. No. 1 kills a white mouse weighing 20 grm. within four days if ⅙ grain be injected subcutaneously. Dropped into the eye in slowly increasing amounts and strengths, these liquids give rise to intense reaction, marked by redness, and swelling of the eyelids, chemosis, enlargement of the neighbouring glands, and so forth. When the symptoms appear likely to exceed the desired end, they may be mitigated by using the jequiritol-serum—that is to say, an antitoxin prepared upon the principle of Behring's serum.

Jequiritol is employed mainly for the clearing of corneal opacities, especially such as result from trachoma, eczema of the cornea, and interstitial keratitis. The agent does not appear to have been much used in this country or in America, although from other parts of the world conflicting reports as to its value continue to appear periodically. One school is represented by Dr. Henri Coppez (*La Clinique Ophthalmologique*, January 25th, 1903) who treated about 100 cases, and succeeded in healing ulcers, clearing pannus, and rendering the conjunctiva smooth. The other school is represented by Dr. Wecker (who introduced jequirity), who dwells upon the dangers and disadvantages of the new agent.

The preparation is expensive, and during its use patients must be confined to bed, or, at least, be made to keep the house. The pain and other discomfort caused by jequirity are serious drawbacks to anything like its general use. These and other considerations have led me to employ jequiritol in a sparing way and in selected cases only. I have careful notes of twelve such cases, and I will endeavour to summarise the results in ten of the cases as follows:—

The series included seven males and three females, whose ages ranged from six to fifteen years. In three both eyes were treated, and in seven one eye alone. The underlying condition which had caused the corneal opacities was trachoma in six instances and eczema in four. Reaction, as a rule, was insignificant until the strongest concentration of jequiritol was applied. Pain, membrane on the conjunctiva, chemosis, vascularity of the cornea, mastoid redness, swelling of the side of the face, enlargement and tenderness of the preauricular and cervical glands, and a rise in temperature to 100° F. or 101° F., were constant accompaniments of the cases in which jequiritol set up marked reaction. The complications of the treatment included abscess of the lacrymal sac—acute in one case, a child suffering from hereditary syphilis, and chronic in two others. In one patient, a girl, æt. 8, affected with active and vascular trachomatous pannus, seven applications of jequiritol led to severe reaction, associated with exfoliation of the anterior layers of the central region of the cornea. It became necessary in this case, the only one in the series, to make two applications of the "heilserum." With regard to the effects upon vision, there was no change for the better in four cases, and slight improvement in the remaining six cases. I am bound to say, however, that in no instance was the improvement in this respect greater than could be accounted for by the mere efflux of time, and was certainly not so pronounced as could have been obtained under simpler, more economical, and less painful methods of treatment.

In my hands, therefore, the results obtained from jequiritol treatment, although of some little scientific interest, are scarcely such as to justify me in undertaking further experiments.

X-Rays.

During the last two years, X-rays, as well as currents of high intensity, have been widely employed in the treatment of diseases of the eye, sometimes with the best results. A timely note of warning, however, has been sounded by Dr. A. Birch-Hirschfeld (*V. Graefe's Archiv für Ophthalmologie*, II., October, 1904), with regard to the use of these powerful therapeutic agents in ophthalmic work. They may, indeed, unless used with proper precautions, cause most untoward complications, as, for example, loss of the eyebrows and eyelashes, inflammation of the conjunctiva, cornea, and iris, and in the deeper structures of the eye such changes as degeneration of the macular region and ganglionic layer of the retina and of the medullary fibres of the optic nerve. Birch-Hirschfeld, therefore, urges that the eyeball should be efficiently protected, and that exposure should neither be unduly strong nor repeated too frequently.

The list of diseases that have been treated with X-rays is already quite a long one, and includes (1) rodent ulcer and epithelioma of the eyelids, and sarcomata and other orbital growths; (2) trachoma; (3) tuberculosis of the conjunctiva; (4) spring catarrh; (5) blastomycetes; and (6) scleritis, superficial and deep.

(1) *Rodent Ulcer, &c.*—The cure of rodent ulcer and

epithelioma of the skin or the eyelids has now gone far beyond the experimental stage. In this connection, I will merely quote Dr. Sweet (*Medicine*, April, 1904) who has treated upwards of twenty such cases, with success in every instance except two. Sweet is of opinion that in our present state of knowledge it is no longer justifiable to resort to the excision of rodent ulcers and epitheliomata of the eyelids. With regard to sarcomata the position of X-rays is not so clear. However, an inoperable case of orbital sarcoma has been reported by Webster Fox (*Archives of Ophthalmology*, January, 1904) where restoration to the normal followed forty-six exposures to the focus-tube. Kienbock (*Woch. f. Therapie u. Hygiene des Auges*, February 25th, 1904) cured a sarcoma, which had produced bilateral exophthalmos and optic atrophy, by thirteen exposures spread over the course of three months. Béclère (*Gazette des Hôpitaux*, June 14th, 1904) has also reported a successful case.

(2) *Trachoma.*—Trachoma has been treated with X-rays by Mayou, Walsh, Cassidy and Rayne, Bettremieux, Goldzieher, Pardo, and myself, with results that, upon the whole, compare most favourably with those obtained by the ordinary methods. Walsh and myself were the first to employ the high frequency current in this intractable disorder. The results were excellent, and cure was obtained, always without pain, and often in a surprisingly short time. It seemed to make little difference whether the current was applied directly to the diseased parts or merely transmitted to them through the closed eyelids. The tedium inseparable from holding the lids everted, as well as the exposure of the nurse's hands, may be avoided by employing the ingenious clip devised by Reid and Edmunds (*Lancet*, August 15th, 1903).

(3) *Tuberculosis of the Conjunctiva.*—I was the first to endeavour to cure this disease by means of X-rays. My patient, a girl, æt. 4, was cured in a month, without visible cicatrisation of the conjunctiva, by thirteen exposures applied for ten minutes at a time, the tube being held six to ten inches away from the eye. In these somewhat rare cases I believe that X-rays will usually suffice without excision or scraping or cauterisation of the affected parts. Moreover, there is always a risk of exciting a generalised tuberculosis when we interfere surgically with these lesions, which as regards the conjunctiva are, in my experience, usually primary.

(4) *Spring Catarrh.*—Recovery of this curious affection by exposure to the emanations of the focus-tube have been reported by Starr, Bennett, and Allport. Allport (*Ophthalmic Record*, October, 1903) first removed the palpebral outgrowths, and then exposed the conjunctiva, everted by means of a lid-clamp, to the action of the X-rays. Cure followed eighty exposures.

(5) *Blastomycetes.*—The best cure for that singular disease, blastomycosis of the skin of the eyelids (instances of which have so far been met with almost exclusively in Chicago, U.S.A.), appears to be by the local application of X-rays, together with the administration internally of large doses of potassium iodide.

(6) *Scleritis, superficial and deep.*—Pardo (*Arch. di Ottalmologia*, January and February, 1905) has treated scleritis by the X-rays, and he claims that "these rays represent a real discovery, inasmuch as up to the present day there is no other direct therapeutic agent, but only means amounting to a purely symptomatic treatment."

Radium.

It would indeed be singular if that mysterious element radium, had not been pressed into service in the treatment of eye disease. As a matter of fact, it has been employed in (1) epithelioma, rodent ulcer, and nævi of the eyelids; (2) trachoma; (3) relapsing inflammation of the uveal tract; and (4) various painful diseases of the eye and surrounding parts.

The method adopted has been simply to place a few mg. of radium bromide of varying degrees of uranium activity (U) in a sealed glass tube, and to apply the little apparatus close to or over the eyelids for a given time. Two points seem to stand out clearly—first, that radium is simpler to apply than the X-rays, and, secondly, that it may be used with comparative impunity about the eye. At the same time our knowledge of the therapeutic values of the a, β, and γ rays respectively may be said to be almost non-existent. The gamma-rays seem to be identical with the X-rays, and it is possible that the therapeutic results obtained from radium are more closely connected with them than with the other emanations, known and unknown, notwithstanding the fact that radium is estimated to give off a very small proportion only of these exceedingly penetrating rays.

(1) *Epithelioma, &c.*—With regard to rodent ulcer as it affects the skin of the eyelids, there can be no doubt whatever that radium is directly curative and that without pain, as witness successful cases reported in this country by J. Mackenzie Davidson (*British Medical Journal*, January 23, 1904), Sichel (*ibid.*), and A. S. Green (*Lancet*, March 19th, 1904). This method of treatment, although by no means always rapid in its results (as in a case of my own) has obvious advantages as compared with surgical measures. Nævi have been treated successfully with radium in several instances by Justus (*Woch. f. Therapie u. Hygiene des Auges*, June 22nd, 1905, p. 302).

(2) *Trachoma.*—Hermann Cohn (*Berliner Klin. Woch.*, No. 1, 1905) cured three cases of trachoma by means of a crystal of radium bromide, enclosed in a thin glass tube, the end of which was employed to touch each trachoma-body from ten to fifteen minutes daily. The observation has to some extent been confirmed and, indeed, even antedated in this country, although it may be noted that Mr. N. B. Harman (*The Conjunctiva in Health and Disease*, 1905, p. 196) obtained no improvement in two patients upon whom he experimented.

(3) *Inflammation of the Uveal Tract.*—Dr. Charles H. Williams (*Trans. American Ophthalmological Society*, vol. X., pt. ii., 1904, p. 269) obtained considerable improvement in a case of inflammation of the uveal tract by one minute applications of radium (1,500,000 U.), carried out for about four months two or three times a week with occasional intermissions. Williams also saw benefit follow the employment of radium in two other cases—ulcer of the cornea, and acute iritis with turbidity of the aqueous humour.

(4) *Painful Affections of the Eye.*—Dr. Darier (*Ophthalmoscope*, June and July, 1905) has made the important observation that the metalloid is capable of relieving pain when applied to the eyelids in such affections as rheumatic iritis, specific choroiditis, orbital neuralgia, and so forth. This result, in Darier's hands, now and then came about from a single application of radium of 240 U. for one or two hours. Besson, in his book upon "Radium and Radioactivity," (reviewed in *Centralbl. f. praktische Augenheilkunde*, June, 1905, p. 177) confirms Darier's observations so far as regards the pain of rheumatic iritis, traumatic irido-cyclitis, and epibulbar carcinoma.

(*To be continued.*)

MEDICAL ASPECTS
OF THE
WAR IN THE EAST:

THE JAPANESE RED CROSS SOCIETY AND ASSOCIATIONS FOR MEDICAL RELIEF.

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The kindness of a correspondent in Tokyo, who sent me an English translation of Wasuke Jikemura's report to the Japanese Government enables me to place this interesting historical sketch before the readers of The Medical Press and Circular.

The Hakuaisha, which means the Philanthropic Association, was organised in the tenth year of Meiji (1877) during the Civil War in Kagoshima, and was the actual progenitor of the present Japanese Red Cross Society. During the war, which lasted six months, Count Tsunstami, a Member of the Council, and Viscount Yuzwiu, conceived the scheme of sending relief to the sick and wounded in the war. They succeeded in enlisting the services of two kindred spirits, who were members of the Senate, Josho Matsudaira, and Tadaski Sakurai, and so the Hakuaisha was inaugurated.

The promoters of the Hakuaisha then approached the Headquarters Staff of the Army sent to put down the rebellion, and on May 1st, 1877, received formal permission to commence operations, which they did at once, tendering their services to the Imperialists and Fudalists alike.

On the termination of the war in the September following, it was decided that the Hakuaisha should be made permanent, and that during times of peace they should work to remedy the defects which the six months' service had made apparent.

In 1886, when the Japanese Government gave its adherence to the Geneva Convention, the members of the Hakuaisha revised their constitution and by-laws in such a way as to allow of their affiliation to the Red Cross Society. The Society was now placed under the patronage of their Majesties and its name was changed to the Red Cross Society of Japan. In the following year the society received official recognition, and the revised rules were published with the Imperial sanction. The society celebrated its twenty-fifth anniversary in December, 1902, on which occasion more than 100,000 members assembled in Tokyo.

Her Majesty had always made it a point to be present at the general meetings of the society, a patronage and support which did much to ensure the success of the Association. For many years past the Imperial family contributed £1,000 a year for the hospital, and £500 a year for the patients, out of personal funds, besides making generous contributions from time to time.

The business of the society is in the hands of ten managers, chosen from the Permanent Council. A President and two Vice-Presidents are chosen from the number of the managers, but their appointment must have the Imperial sanction.

The Permanent Council consists of thirty members, residing in Tokyo, who are elected by the society at its annual general meeting. Three inspectors are likewise elected at the same meeting. The following are the present officers of the Society:—General Director, H.I.H. Prince Kanin. President, Count Masayoshi Matsukata. Vice-Presidents, Baron Yoshikata Hanabusa, Baron Takeo Ozawa. The local branches follow the lines of the administration. There is a local branch in every prefecture and the Prefectural Governor is always *ex officio* chairman of the branch. The membership is of three kinds, honorary, special, and regular. Each class has its own badge, and special badges of honour are given to those who have rendered special services to the society. Membership badges are not given until the names of the new members have been reported to his Majesty; the conferring of badges of honour requires in every case the Imperial sanction. The badges may be worn on public occasions like decorations. In December, 1887, there were only about 2,100 members; at present the membership is about 895,000.

During the China-Japan war, 1,587 persons were employed by the society in the work of nursing and medical relief. These persons assisted the Military Sanitary Corps in their work, at home, in the Reserve military hospitals established at Hiroshima and nine other places, and abroad, at the various Etape and fixed field hospitals in Korea and China. They also served on board hospital ships and on transports in attending on wounded and invalid troops. The total number of patients cared for in Tokyo and elsewhere during the war, including those in the Etape hospitals in the island of Taiwan, during operations subsequently undertaken in that island for the suppression of insurrection, was 101,423. Of these, 1,484 were prisoners. The work of the Head Office during the same period was as follows:—(*a*) Sending, free of cost, many thousands of gifts and presents from all parts of the country to soldiers in the field; (*b*) entertaining troops on their way to the front, and welcoming them on their return; (*c*) visiting patients in hospitals, both in Japan and on the field.

During the operations in North China in the summer of 1900, the society was represented by 491 persons engaged in the military hospital at Hiroshima, as well as at Taku, Tien-tsin, Tung-chow, Shan-hai-kwann, and elsewhere. Two vessels, the *Hakuai Maru* and *Kosai Maru*, were at the disposal of the society, and many patients were thus conveyed between Taku and Hiroshima. The total number of persons relieved was 11,348, including 245 Frenchmen and 4 Austrians.

The relief work of the society has not, however, been limited to the care of sufferers in war. Japan is a volcanic country, and as such is liable to natural catastrophes of a terrible kind, such as are almost unknown in countries more favourably situated. During the thirty years which have elapsed since the first organisation of the society, the country has been visited by two or three great earthquakes, and one tidal wave of appalling proportions, to say nothing of hurricanes, famines, pestilences, and fires. In all these calamities the Red Cross Society has always been ready whenever required to stretch forth a helping hand.

Before the outbreak of the war with China neither the staff of the society nor the stock of materials in hand were adequately prepared for the strain of a sudden emergency. The society, however, gathered experience as it worked, and by degrees evolved a methodical and sufficient organisation not alone at the Head Office, but also at the various branches throughout the country.

According to the latest reports, the society has on its books the following *personnel*:—Superintendent medical officers, 14; medical officers, 273; apothecaries, 45; nurses, 1,920; male nurses, 763; probationers, 457. All these are under the direct control of Baron Hashimoto, Surgeon-General and Chief Medical Officer of the Red Cross Hospital. The material resources of the society are reported as follows:—Hospital ships, 2; medical cases, 398; instruments, sets of, 1,774; stretchers, 496; patients' clothes and bedding, 52,438; nurses' clothes and bedding, 27,199; miscellaneous articles, 2,060.

THE SOCIETY'S HOSPITAL.

This important institution was first established in 1876, under the name of Hakuaisha Hospital, in Iidamachi, Tokyo. It changed its name with the society, and was removed to a piece of land belonging to the Crown at Shibuya. The new hospital, which was much larger than its predecessor, was completed in May, 1891. Attached to the Hospital is a training school for nurses and medical attendants who are thus fitted for the special work of the society in times of war and catastrophe. In order to give the students opportunities of practical work, ordinary patients are received in time of peace, but it is an understood thing that in the event of war the hospital shall at once be placed at the disposal of the military authorities as a military reserve hospital. It was so used during the China-Japan War.

Red Cross Work at Chemulpo.—The care of the Russian seamen wounded in the action at Chemulpo was undertaken by the Special Japanese Committee of the Red Cross Society in Japan, aided by the Chemulpo Ladies' Relief Association. On February 13th and 14th, twenty-four Russian sailors were received into the English Church hospital at Chemulpo, kindly placed at the disposal of the Japanese authorities, and their comforts were well looked after, thanks very largely to the sympathetic assistance of the foreign community at the port.

The Russians were at first disposed to shrink from their Japanese doctors and nurses, but kindness soon broke down the barriers, and in a very few days after their arrival it was observed with pleasure that the convalescent patients were offering their aid to the nurses in the treatment of the others. The Chief Surgeon of the *Naniwa* was specially sent to the hospital by Rear-Admiral Uryu to inquire after the wounded, and bear them the Admiral's message of sympathy, an act of courtesy which was much appreciated and duly acknowledged by the wounded seamen.

Hospital Ships.

Immediately on the outbreak of hostilities, Japan notified to Russia that in accordance with the provisions of Articles I. and II. of the Geneva Convention, the following ships had been appointed as hospital ships for the relief of sick, wounded, and shipwrecked persons—to wit, the *Saikyo Maru* and *Kobe Maru*, chartered by the Japanese Government, and the *Hakuai Maru* and *Kosai Maru* belonging to the Red Cross Society.

Sympathy of Foreign Nations.

On February 14th, 1904, the Japanese Minister at Berlin telegraphed to inform the President of the Red Cross Society of Japan that the German branch of the society was prepared to send nurses and surgical appliances and apparatus in case of need. On the same day the French branch of the society telegraphed their warm sympathy with Japan and offered to send a contribution of surgical material and a body of trained nurses, if required. The Red Cross Societies of Italy and Spain also offered contributions of material, aid, and appliances for ambulance work. The German Emperor telegraphed to the Empress of Japan placing the German Naval and Military Hospitals at Yokohama and Chingtao at the disposal of Japan. And an American lady proposed to come to the assistance of the Japanese Red Cross Society with a large number of trained nurses. To all these offers the Japanese Government, on behalf of the Red Cross Society, sent messages of gratitude accepting the offered contributions of appliances and apparatus, but declining the proferred services of the trained nurses.

Associations for Relief-Work.

Some of the many associations existing in Japan for the care of the sick and wounded in war, and the relief of the families of soldiers and sailors, in the field, which have lost their breadwinners, are the following :—

1. *The Association of Volunteer Nurses*, which was first organised in 1887, draws its members from the Imperial Princesses, the Court Circle, and the wives of the nobility and gentry, the present General Director and President being H.I.H. Princess Kanin, and the Marchioness Nabeshima. The members of the Association make it their duty to study nursing so as to be ready for practical service in time of war. During the China-Japan war the members of the association made bandages for the use of the Army and Navy Medical Departments, and served as nurses in the reserve hospitals in Tokyo and Hiroshima ; and again, at the time of the operations in North China, they raised funds for presents to the sick and wounded, both Japanese and foreign, who were visited by their representatives in the hospitals at Hiroshima and other places. The Head Office of the Association is at the Red Cross Society's building in Tokyo ; and there are thirty-two local branches in different parts of the country. The present membership of the Association is as follows :—Head office, 427 ; local branches, 4,200.

2. *The Ladies' Patriotic Association* draws its members from the same circles as the above, and has for its object to relieve the families of those who have died in action or during military service, and to care for those who are permanently disabled. The General Director of the Association is H.I.H. Princess Kanin, and the President, Princess Hisako Iwakura. The main office is in Tokyo, and there is a local branch in each prefecture. The Association, has recently received the following contributions from members of the Imperial Family: H.I.M. the Emperor, £700 ; H.I.M. the Empress, £500 ; T.I.H. the Crown Prince and Crown Princess, £250.

3. *The Imperial Relief Association for Soldiers and Sailors* was established by nobles and prominent gentlemen in Tokyo with the same objects as the two above associations. The President is H.I.H. Prince Arisugawa, the Vice-Presidents, Counts Matsukata and Inone. It is situated in Tokyo, and its originators during the early months of the war, contributed more than £100,000. The subscription list was headed by a donation of £10,000 from their Majesties ; £1,000 from the Crown Prince ; £500 from Prince Arisugawa, President of the Association ; and £300 from the other Imperial princes.

4. *Volunteer Relief Work for the Marines.*—The wives of the Japanese naval officers also have combined to raise money and contribute articles, in order to give comfort for the naval officers and men in the campaign. The orginators of this work are Mesdames Tomiko, Takagi, Shigeko Uryu, and Haruko Saito. The students of the Peeresses School, numbering about 426, under the command of their teachers, some 480 in all, every afternoon when school is over, employ their time in preparing bandages and so forth for the military hospitals.

NOTES ON CASES OF GONORRHŒA TREATED WITH ARGYROL.

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There is probably no disease which is followed by so many undesirable sequelæ or which presents so many difficulties with regard to treatment as that form of specific urethritis to which we apply the term gonorrhœa. There is certainly no disease in which patients show so much persistent wilfulness, such impatience of control and such disbelief in the remedies indicated by the surgeon, should they fail at once to produce a curative or at all events an ameliorating action. It is not too much to say that the keynote to successful practice is the ability to deal with a patient suffering from gonorrhœa, or still worse, a long-standing gleet. Nothing requires greater firmness, greater tact, and above all, so intimate a knowledge of details in modes of procedure.

The remedies for the disease may be divided into two categories, the local and the constitutional. In my opinion, as in my practice, I lean towards the former to the exclusion of the latter, with, however, this proviso—that by constitutional remedies I mean those such as copaiba, cubebs, sandal-wood oil, &c., which are supposed to exert a specific curative effect on the urethral mucous membranes, and not simple adjuvants—purgatives, salines, diuretics and so on—which are administered at certain stages of the disease for the relief of constitutional departures from health. Without hesitation I admit the utility of the latter, but for the cure of gonorrhœa I pin my faith to injections and local remedies to the exclusion of drugs administered for specific purposes by the mouth. I do not know that it is necessary for me to dilate on this point, for I have entered very fully into the discussion of the subject in my work on "Syphilis and other Venereal Diseases." I unhesitatingly declare myself to be a believer in urethral injections, and my opinion is founded on the results of the careful observation of many thousands of cases during the last thirty years in hospital and private practice.

The first indication obviously is, as in all forms of inflammation, to get the patient's constitution into the most favourable condition for the subsidence of the irritation : this is a matter which requires some consideration, and a careful study of the peculiarities of the individual. It is a mistake always to begin with purgatives and antiphlogistics as a routine treatment, for although undoubtedly these are indicated in the case of a strong, healthy, and full-blooded man, they are of little use in a delicate, anæmic lad of feeble muscular and constitutional development, to whom a course of a reliable preparation of iron or even a basin of good soup would prove of more benefit than a dose of jalap or a black draught.

The local treatment in the form of an injection may be commenced at once, even when there is a great deal of inflammation and much scalding in passing water, I may say here that I am not in favour of the irrigation of the anterior, much less of the posterior, urethra, as advocated by many writers. I consider that injection, properly given and with a properly shaped glass syringe will answer every purpose, and this quite apart from the much greater convenience to the patient himself. The choice of a formula for injection is a matter of some importance, and for many years my favourite prescription was the following :—

Zinci sulphat., grs. 8. ;
Tinct. lavandul. co., ½ dr. ;
Aq. rosæ, 4 oz. ;
Aq. distill. ad., 8 oz.

The strength of the injection is gradually increased as the patient improves. On the whole this treatment has yielded excellent results. Still it was not invariably successful, and on some occasions I was glad to fall back on acetate of lead, chloride of zinc, sulphate of copper, and permanganate of potassium. Even these were not infallible, and could not always be trusted to effect a cure.

Against the employment of nitrate of silver as an injection I must confess to having entertained a strong prejudice, for I felt some hesitation in using such a powerful caustic in cases in which I could not watch and control its effects on a mucous membrane so delicate as that of the urethra. I argued that a very weak injection of nitrate of silver might possibly be useful in an old gleet, but never in the course of gonorrhœa.

My attitude with respect to the use of injections of a solution of silver salt has, however, undergone a considerable change since the introduction of argyrol. which is a combination of argentum and vitellin, and although it contains 30 per cent. of silver it is, in my experience, absolutely free from all irritating effects. I have employed it freely at the French Hospital, where I have investigated its properties as an injection for urethral discharge. In this investigation I have been materially assisted by one of my colleagues in the out-patient department. Judging from my own experience of argyrol as a urethral injection I have no hesitation in saying that the results from its employment are distinctly favourable. In not one of my cases has it produced the slightest pain or irritation, either at the time of the injection or subsequently, although I have employed it when there has been profuse discharge and a large amount of inflammation and irritation not only in the urethra, but of the whole penis. This mode of treatment appeals to me strongly, for I maintain that the inflammation and irritation are due to the discharge, and that a bactericide which tends to allay the excessive secretion cannot increase the inflammation, but must of necessity lessen it. By using argyrol it is possible to obtain the local good effects of silver much more readily, and with much greater certainty and safety than with the nitrate; for argyrol is not caustic and may be employed even in a 20 per cent. solution without producing any irritation or deleterious effects. One of the most striking effects of the injection of argyrol is the prompt relief given to pain and smarting attending micturition. There is no doubt that it kills gonococci, and whilst curing the discharge probably lessens the risk of constitutional disturbance and of the occurrence of gonorrhœal rheumatism.

In illustration of these points I append notes of a series of cases recently under my care at the hospital. They were severe cases, and consequently afford an excellent test as to the value of the remedy. They were not specially selected, but were taken in the order in which they presented themselves for admission.

A man, æt. 23, was admitted with gonorrhœa, the incubation period of which had been four days. The discharge was profuse and of a creamy consistence, and the patient complained of ardor urinæ. There was a painful swelling of the glands in the left groin. The patient was given a simple purgative and was ordered a 5 per cent. solution of argyrol, to be used as an injection three times a day. He was carefully instructed as to the method of using the injection, a point to which I attach paramount importance, as no injection can be expected to prove efficacious unless administered in an intelligent manner. On the twelfth day the discharge had completely disappeared. He was kept under observation in the ward for a few days longer as the enlarged glands continued painful and tender. As a precautionary measure he was given on leaving the hospital a supply of the injection to be used for a short time.

The result in this case was extremely satisfactory, for in my experience, gonorrhœa properly treated, even when all hygienic directions recommended are faithfully observed, often lasts two or three, occasionally six to eight, weeks, and then sometimes leaves behind a gleet, which is the bugbear of the surgeon and the *désespoir* of the patient.

The next case was a severe one from the fact of its being complicated with epididymitis. The patient, a man æt. 29, was admitted with gonorrhœa and left epididymitis. The discharge had been very profuse and thick, but had decreased in amount on the onset of the complication, a condition which I may remark is very common. A peculiarity in this case was that the patient affirmed that the discharge did not appear until three weeks after the last connection. He was an intelligent man, and his statement could not be shaken. The epididymitis was noticed ten days after the onset of the discharge. On admission, there was some elevation of temperature, the epididymis was very tender, but there was no marked tenderness of the testicle or penis. As in my opinion the best way of treating epididymitis is to cure its original cause, I prescribed a saline purgative and a 5 per cent. injection of argyrol, hot fomentations and belladona being applied to the scrotum. Ten days after admission the discharge had entirely ceased, and there was so little tenderness of the epididymis that I ordered the testicle to be strapped preparatory to sending the patient out. Unfortunately the right epididymis became slightly tender and the discharge returned to a small extent. A repetition of the argyrol injection once more answered promptly, and in a few days the patient was completely cured. The second mild attack of epididymitis was clearly not due to the injection, for had such been the case, the original very acute and painful attack on the left side would have been aggravated.

The next case occured in an anæmic subject, a man, æt. 24. He had a profuse gonorrhœal discharge, with a certain amount of ardor urinæ. The period of incubation was three days. He was given a saline purgative and an injection of a 5 per cent. solution of argyrol to be used three times a day. Seven days after admission he went out absolutely cured, there being no pain and no discharge. This I consider to be a very satisfactory case, for although there were no complications the patient made an exceptionally rapid recovery.

The following case illustrates the benefit of the treatment in the latter stages of gonorrhœa :—

A plethoric individual of sedentary habits, æt. 48, presented himself for advice at the end of the fourth week of the disease, He had taken capsules of various kinds, and had used a variety of astringent injections without, however, effecting a cure. It was not his first experience in this direction, and as in former attacks he had suffered from orchitis and other complications he was anxious to get well. The acute stage had subsided, but there remained a scanty mucopurulent discharge containing few gonococci. He was ordered a 5 per cent. solution of argyrol to be used as an injection twice a day, and retained in the urethra for at least from one to two minutes. He used only eight injections and then reported that the catarrhal condition had entirely ceased, and that the urine was free from shreds. He was seen again a week later, and stated that there was no further need for treatment. The case is the more satisfactory as it is the mucous-terminal stage of gonorrhœa which is often so persistent.

The next case was one of mixed infection. The patient was a man, æt. 25, who had gonorrhœa for three weeks. The incubation period was two or three days from the last coitus, but it was clear that there had been a previous connection as the result of which he had contracted syphilis. He had a hard chancre on the penis with indolent glandular enlargement in the left groin. The gonorrhœa was treated with a 5 per cent. solution of argyrol as an injection, and was cured completely in a fortnight. The man was given anti-syphilitic remedies and told to attend as an out-patient.

It seems useless to multiply the records of these cases for they present a striking similarity and differ only in matters of detail. Equally good results have been obtained among out-patients and in private practice not only in acute cases but in those of long standing.

I have used chiefly the 5 per cent. solution, but after the first few days the strength may be raised to 10 or 20 per cent. without the slightest danger of producing irritation, even in acute cases. If the patient is seen quite early, that is within the first forty-eight hours, the abortive method which consists of the injection every three hours of a 20 per cent. solution may be resorted to with advantage. It is in the first few weeks of the disease, when gonococci are present in the secretion in large numbers, that argyrol exerts beneficially its powerful antiseptic properties. In the sub-acute stage, however, when there is still a discharge, semi-purulent in character and containing a few gonococci it is better and safer to continue the argyrol injection until a complete cure is effected.

Among cases treated on these lines and without the administration of internal remedies the following have been observed. (1) A medical student, æt. 22, who had gonorrhœa with orchitis which was cured in a fortnight. (2) A man, æt. 25, who had had a thick, white urethral discharge for five months, and was cured in three weeks. (3) A man, æt. 28, who as a result of a gonorrhœa contracted nine years previously suffered from a morning drop (goutte militaire) which promptly disappeared after a 20 per cent. injection of argyrol. (4) A man, æt. 24, who had gleet with "goutte militaire" of over a year's duration, and was cured by six injections. In all these cases various other modes of treatment had been employed unsuccessfully.

In cases of gleet complicated with cystitis urethral injection alone cannot be relied upon to effect a cure, and the slight inflammation of the posterior urethra and of the neck of the bladder may advantageously be treated by the introduction of a 5 or 10 per cent. solution of argyrol into the bladder, allowing it to be retained for a short time and then to be passed naturally by the patient. This mode of treatment in which I generally employ strong boracic or quinine solution is with argyrol, free from danger and still more efficacious.

Speaking as the result of my experience I have no hesitation in saying that argyrol is a very valuable remedy for all kinds of gonorrhœa. One great advantage, in my opinion is, that in no case has it produced the slightest irritation or pain either at the time of injection or subsequently. It is a source of satisfaction to me that I have added argyrol to my armamentarium in the treatment of specific urethral discharges, besides it is an enormous advantage to have at one's disposal a silver preparation which, whilst curative, is non-irritative, and may be employed as an injection in all stages of gonorrhœa as well as in gleet.

It hardly falls within the province of this paper to deal with the sequelæ of gonorrhœa, but I may mention that in the treatment of gonorrhœal ophthalmia there is no more efficient remedy than the instillation of a few drops of a 5 per cent. (or even stronger) aqueous solution of argyrol.

THE RECENT FALL IN BIRTH-RATES:

ITS EFFECTS ON DEATH-RATES.

By C. R. DRYSDALE, M.D., M.R.C.P., F.R.C.S.

The Registrar-General's report for 1877, page lxxxvi., tells how the mean rate of mortality in London for the thirty-eight years between 1840 and 1877 was 24 per 1,000 inhabitants. And yet, that was the time when sanitarians, like Sir Edwin Chadwick and Sir B. W. Richardson, had accomplished so much for the drainage and cleansing of London. Such praiseworthy efforts, however, were rendered nugatory, as regards the main aim of hygienists—*i.e.*, the lowering of the death-rate. The average birth-rate of London for the thirteen years prior to 1877 was 36 per 1,000 inhabitants. This birth-rate has greatly declined since 1877, for, in 1904, the birth-rate of all London was 27·9 per 1,000.

This fall in the birth-rate has occurred in almost all civilised countries since 1877, and its cause has been correctly attributed by Dr. Billings, of the United States Registry Office, to the voluntary lessening of the children to a family. One of the most modern cities, Chicago, U.S.A., with a population in 1902 of 1,608,000, had the very low birth-rate of 15·0 per 1,000 inhabitants, and a death-rate of only 13·5 per 1,000, so that the inhabitants of many cities in the United States have much lower birth-rates than London has at present.

The fall in the birth-rate has extended to most European countries and to our own favoured colonies. Thus, the births per 1,000 of the population fell since 1871 to 1895 in—

Germany ..	from	39.0	to	36.3
Austria	„	39·5	„	37·5
Holland	„	36·1	„	33·0
Great Britain ..	„	34·1	„	29·6
England (in 1901)				27·9
Belgium	„	32·2	„	29·2
France	„	25·5	„	22·6
Italy	„	36·8	„	36·3

All these States have had their birth-rates lowered. Not to speak of Germany, the fall in Austria was, in twenty years, 6 per cent.; in Switzerland, 7 per cent.; in Great Britain about 13 per cent.; in Holland about 9·0 per cent.; and even in France about 12 per cent. Our colonies have imitated us, for the birth-rate in Australia fell from 41 per 1,000 in 1861 to 26 per 1,000 in 1899, and in New Zealand a similar fall in twenty years took place.

What effect has this fall in the birth-rates produced in lowering the death-rates? In the decade, 1871 to 1880, Germany saw its death-rate fall from 27·1 to 23·3; Austria, from 31·5 to 27·8; Holland, from 25·4 to 19·6; England from 21·4 to 16·9 in 1901; Belgium, from 33·3 to 30·3; France, from 23·6 to 22·3 in 1895.

We see by these figures that the fall in the birth-rates of the civilised world has produced a great fall in the death-rates. The obvious meaning of these results is that, as the race of animal to which man belongs could easily double its numbers in about twenty-five years, there is always a pressure on food supplies, which causes the premature death of the less thoughtful classes who follow their instincts of procreation without due consideration.

High birth-rates in all European countries are the main cause of high death-rates, and especially high infantile mortality, because they cause scanty feeding, crowding into great cities, and deaths from zymotics and phthisis—*i.e.*, high birth-rates are the main cause of poverty, which again is the origin of early death and disease. Sir Edwin Chadwick, in a pamphlet "On the Dwellings of the Wage-earning Classes," which he gave me in Paris in 1877, showed how misleading it was to talk of the death-rate of any large city. There were districts, he said, in London, where the death-rate did not exceed 11 per 1,000, while there were adjacent streets where the death-rate rose to 38 per 1,000. That able statistician, in 1843, made an inquiry into the district of Bethnal Green, when the death-rate of London was 24 per 1,000, as it was for more than thirty years subsequently. From this inquiry, it appeared that the gentry and professional classes of Bethnal Green had a death-rate from zymotics of 6·6 to all deaths, whilst the labouring classes had 22·2 per cent. There was a death-rate of 1 in 10 infants of the comfortable classes in their first years of life, and 1 in 4 among the labourers.

Dr. Villerme, of Paris, in 1834, showed that, between the ages of forty and forty-five the death-rate of persons in easy circumstances was three times lower than that of the poor of like ages. The late Dr. Janssens, of Brussels, gave similar figures for the rich and poor of Brussels. He showed that the families of the poor were thrice as numerous as those of the districts around the Park; and that the death-rate from consumption was 6·6 times as high in the poor streets as in the rich quarter. M. Lagneau, of Paris, mentioned that in the poor quarter of Plaisance, in Paris, the death-rate from phthisis was ten times as great as it was in the districts of the Champs Elysées. M. de Haussonville showed that the families of the poor in the poor districts of Paris contained thrice as many children as those in the rich quarters of Paris. Dr. Edward Smith found at the Brompton Consumption Hospital that the parents of the patients afflicted with that disease had given birth to 7·5 children on an average. The patients of the Metropolitan Hospital, when situated in Whitechapel, showed that one hundred married women over the age of forty-five had produced 740 children; whilst Dr. Lutaud, of Paris, gives the statement that the wives of the Parisian medical practitioners produce only about 150 children to one hundred wives.

Mr. Charles Ansell, of the National Assurance Company, estimated that in the year 1873 poverty destroyed 143,130 lives in England and Wales.

With regard to the death-rate of infants in the first year of life, Ansell found that among the richer classes in 1875, 80 per 1,000 of these children died; whilst we have heard that in several of our manufacturing towns, such as Preston, the infantile death-rate is sometimes as high as 400 per 1,000 born.

In the year 1898 the Board of Physicians of the city of Hamburg published some statistics relating to infantile mortality and the family income. In the well-to-do quarter of the city—Harvesthude—the average income per head was £141, and the infantile mortality was 2 per 1,000 inhabitants. In a poor district—Horn—the income per head was £15, and the infantile death-rate 10 per 1,000 inhabitants. In London, in 1874, the death-rates in the poor districts were much higher, as well as the birth-rates, than those prevailing in the richer districts. The following are the birth- and death-rates per 1,000:—

Stepney	37·0 ..	18·0
Finsbury	37·0 ..	20·3
Bethnal Green	35·7 ..	20·3
Poplar	34·5 ..	18·2
Westminster	16·9 ..	13·6
Hampstead	17·1 ..	10·0
Kensington	18·0 ..	15·0

These imperfect statistics prove clearly that the death-rate of the poorest classes is very much higher than that of the well-to-do classes, and that their birth-rate is twice and sometimes thrice as high. We may safely conclude that in European countries the main cause of high death-rates is large families, and that, if we really desire to improve the health of the classes at the bottom of society—which is the object of hygienic science—we must in future endeavour to persuade these unfortunate classes to have families not exceeding three or four children, as the richer classes are doing. If the birth-rate in this country were to fall to 15 per 1,000 and the death-rate to 12 per 1,000 that would give a surplus of healthy children of 126,000 annually, which would amply suffice for colonisation, so long as that temporary phase of society may require emigration. We ought to endeavour to reduce our infantile death-rate to 60 per 1,000 born, and extirpate phthisis and other *neoplasms of poverty*, so that all who are born may attain the ages of eighty, ninety, or one hundred years.

Special Articles.

EARLY HISTORY OF THE MEDICAL PROFESSION AND OF HOSPITALS.—I.

The earliest Greek medical operators, who, as surgeons, sought the Roman capital, where their services gradually became indispensable, deduced their origin from the most degraded of the conquered populace—such, for example, as attended on the public and private baths, servants in the gymnasiums of the diverse municipalities of Greece, or assistants in the Hellenistic pharmacies. Frequently these adventurers arriving from their country as slaves and bondmen, and quickly assuming at Rome the title and condition of freedmen, opened booths on the public streets, and offered their wares for sale—medicaments prepared by themselves. In these places the indolent and unoccupied assembled for the purpose of whiling away the time, and in quest of the news of the day. Consequently the practitioners of medicine at Rome presented no unusual attraction for the gracious respect of the citizens; and as the healing art remained in the hands of freedmen, it was regarded, indeed, as a vile and degraded traffic, suitable only for the servile condition of slaves. From whatever causes were developed Roman hatred, it appears to have extended back as far as the second century prior to the Christian era, to the time of Archagathus, a Peloponnesian surgeon who came to the city of Rome in order to exercise his vocation. From the Senate he received the right of citizenship, and a medical book purchased for him with public funds. He subsequently lost the respect of the patricians, and fell into contempt on account of the cruel nature of his surgical operations, which, as in more ancient times, consisted in cauterising and incisions.

Towards the age of Julius Cæsar, Greek physicians began to acquire greater privileges. One of the foreign surgeons who appears to have fully merited the considerate immunities extended to medical men at this period, Asclepiades of Bithynia, succeeded in grounding his curative system upon a philosophic or scientific basis. The medical economy of Asclepiades involved largely the use of wine as a medicament, and frequent baths of cold water as a sanitary element. During the government of the Roman Commonwealth by the Senate, in early ages, the practitioners of medicine possessed, as a body, no legal status. The enlightened policy of Julius Cæsar elevated the character of the surgeons and physicians of the metropolis by conceding to them the franchises of citizenship. By such judicious concessions, this valuable profession was at once made honourable in the eyes of the people, and henceforth stood forth as an avocation which had obtained the honours of specific illustration at the hands of the celebrated warrior and statesman.

Of the scholars of Asclepiades, Antoninus Musa was, without question, the most worthy, inasmuch as his successful treatment of the future Emperor Augustus, by means of cold lotions and saturated wraps, saved him from a dangerous illness. Of all the prerogatives with which the devotees of medical science had been previously endowed, none equalled the grateful immunities of Augustus after his preservation by Musa. By a rescript promulgated by the Imperial authorities, all surgeons were declared thenceforth for ever free from public impositions of every description and enfranchised of all taxes, while at the court of the emperor a highly salaried surgeon was regularly engaged. Such arrangements unquestionably largely aided in permanently establishing the social dignity of members of this assocation, and contributed to the development of medical science. After the time of Julius Cæsar, great numbers of Greek surgeons were domiciled in Rome about which period the names of several army surgeons of this nationality appear. The quaint notice is made of surgeons recruited for the Roman legions under the distinctive nomenclature of medici legionum and medici cohortum.

Soramus, surnamed the younger, in order to distinguish him from the renowned physician of the first century, prepared an elaborate work on obstetrical treatment, a branch of surgery anciently entrusted to female care, and in the Roman Empire regulated by proper legislation. Soramus the younger is known as the oldest historian of the curative art. Moxhion, apparently his disciple, distinguished himself as the author of the first treatise on midwifery, entitled "De Mulierum Passionibus Liber." He especially cautioned in such cases against an antiquated custom of severing the umbilical cord with a wooden or glass fragment, but in the place of these directed the use of a sharp blade. Roman zeal for the cultivation of a taste for natural history and the kindred science of medicine, influenced two illustrious citizens of the Empire to acquire the mastery of the entire range of contemporary sciences, and, although subject to the curious superstitions of the age, to become profoundly skilled in a knowledge of the curative art. Of these, Aulus Cornelius Celsus, in the time of Augustus, carefully collated an enormous encyclopædia, of which the sections treating of medicine are yet extant in eight books (" De Medicina, Libri Octo"). In this work we possess a fine specimen of the intellectual industry and scientific research of an enthusiastic scholar ; he has collected the wisdom of preceding ages and aggregated in exact adjustment the productions of learning of Hippocrates and Asclepiades, Archagathus, and Israelitish and Arabic physicians.

The other celebrated scholar, Caius Plinius Secundus, of Como, on a more enlarged scale, indeed, than Celsus, mastered the entire range of natural science and arts, and reduced them into encyclopædic form. The thirty-seven books of natural history present a marvellous repertoire of manifold wisdom. The principal object of the curative art seems to have been the invention of unusual remedies, strangely compounded, while the medical adviser assumed the attitude of a professional empiric. Out of this system grew unnumbered receipt books prepared for practical use. the value of which was attested by actual experiment. None of these collections attained the celebrity enjoyed by the comprehensive work on " Herbal Medicaments " of Dioscorides, a native of Anazarabia, in the reign of Nero. This compilation maintained its repute with undiminished vitality through the Middle Ages to modern times. Among the vegetable remedies known and recommended by Dioscorides, were ginger, pepper, aloes, sugar or saccharine matter, &c. In addition to these he suggests the free use of elm bark against pustular maladies. Rules were established by him for the prompt detection of adulterated medicaments, while his intimacy with metallic remedies, whose preparation evidently required an apparatus of fine implements, presupposes a knowledge of chemical action.

To the epoch of Christian emperors must be assigned the first serious attempt at medical organisation. This rapid increase of surgeons ultimately necessitated their subjection to a supreme head whose dignity was designated as Archiatrus popularis, whose official duty was identical with that of a physician salaried by the State. For the purpose of establishing the lawful privileges of this professor on a basis of correlative duties and substantial enfranchisement, the Emperor, Antoninus Pius, about the middle of the second century, issued an edict in the nature of a medical ordinance, which prescribed that cities of the smallest number of inhabitants should be entitled to have and maintain five physicians absolutely freed of all and every kind of public service, intermediate towns and villages were privileged to possess seven, while the largest metropolitan cities obtained an enlargement of privileged surgeons to the number of ten, within the municipal limits of the great capital of the Empire, each of the fourteen *regiones* or departments was allowed a medical attendant whose salary was fixed by law. The Vestals and Gymnasia also were permitted a surgeon regularly employed at public expense.

Compensation for professional skill consisted chiefly in kind—*annonaria commoda*, or natural productions, sometimes in money or its current equivalent, usually styled *salara*, as distinguished from the honorarium or fees, which more accurately applied to the law than to medicine. Upon the principle of receiving State or Government patronage, the members of the medical profession thus salaried were likewise obliged to perform certain functions partaking eminently of a public service. Consequently, it was their official duty to render attendance to the impoverished without compensation—a system of absolute necessity arising from the disinclination of the affluent and aristocratic Romans to subject himself to the hazard of infection, which was carefully avoided on the return of the messenger to sick friends, by compelling the servant to bathe himself before presenting the result of his inquiry. In the case of wealthy sufferers the departmental physician was allowed to demand his honoraria, or fees. To these emoluments arising from their official position, municipal surgeons added the substantial benefits of the dignified Archiatria, by an exemption from such imposts as military obligations, quartering, forced loans, &c. In matters requiring judicial inquiry, these privileged officials were favoured with a speedier disposition of their causes before the tribunals where they were called—a prerogative of the highest value under the complicated and tedious proceedings which the Roman advocates were skilled in prolonging in exact proportion as the gilded honoraria of the clientèle failed to stimulate his judicious hesitancy. Antoninus Pius enacted that these public surgeons should be exempt from summary process and interdicted the issuance of a warrant against them to bring their body before the Courts. This rescript was reaffirmed by Constantine in the year 321, under most exemplary fine and the penalty of being flayed alive.

Towards the commencement of the third century an edict was promulgated which rendered medical practitioners responsible for the pathological treatment of their patients and forbade for such purpose the application of magic. Permission, however, restoring certain remedies of a magical nature was subsequently decreed by Constantine the Great in the year 321. In order to hold in subjection a tendency so rapidly increasing at this epoch, to apply supernatural curatives, a law was passed adjudging the delinquent to the death penalty.

One of the most singular and, in its moral influences on the Roman society, destructive customs, traceable to the deteriorating presence of Greek refugees in the Imperial metropolis, was the universal extension of the emasculation of infants to qualify them for a terrible servitude. The mortality of this deformity may be conjectured when it is stated that only one of thirty survived the mutilation. Severe laws were promulgated by the emperors in order to totally extinguish this inhuman practice. The penalties inflicted for violating these ordinances were emasculation by way of retaliation, banishment, and confiscation of the offender's personal possessions.

Towards the conclusion of the third century the first indications present themselves of the existence of a class of citizens to whose vigilant care was confided the preparation of medicaments ordered by attendant physicians. Prior to this epoch, for several centuries it had been the most usual method for medical practitioners to compound their own medications and administer them to their suffering patients. Regular pharmacists were entirely unknown, excepting perhaps the *Herbarii*, who disposed of their commodities at trifling prices in the public markets or along the highways. There was, indeed a class of medicinal compounders whose operations were mainly limited to the preparation of such remedies as experience or current rumour suggested to be most suitable for popular merchandise, and offered their wares upon benches or stalls, in booths denominated *apothecæ*, directly for public sale. For this reason they were classified as *medici sellurlarii*, but the market vendors of medicaments by outcry were known as *medici circumforanei*, or *circulatores*. Physicians themselves, in preparing proper remedies for their sick, usually purchased pharmaceutical supplies from these medicinal merchants.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, August 19th, 1905.

CHRONIC PROSTATITIS AND TREATMENT.

CHRONIC inflammation of the prostate gland, a very frequent affection of which the consequences can be so important, occupies but a very restricted place in classical works. It is only within the last few years that it has taken a prominent place in urinary pathology. Dr. Le Fur made some interesting communications on the subject at the French Society of Urology, of which the following is a *resumé* :—

From an etiological point of view, chronic prostatitis may be divided into two classes—infected and aseptic prostatitis. The former is characterised by the presence of microbes and pus in the secretions of the gland, while the latter can be primary aseptic (absence of microbes or pus), consisting in modifications of the glandular secretion (hypersecretion, secretions modified in their chemical composition), or aseptic after infection of the gland, due for the most part to gonorrhœa.

The causes of infected prostatitis are numerous: Gonorrhœa, stricture, hypertrophy of the prostate, traumatism (introduction of instruments, injections), urethritis, non-blenorrhagia, cystitis, pyelo-nephritis, acute enteritis, muco-membranous entero-colitis, hæmorrhoids, constipation, stricture or cancer of the rectum.

Other causes are due to general infection: Grippe, mumps, typhus, measles, tonsillitis, arthritism, &c.

Aseptic chronic prostatitis is characterised by hypersecretion of the gland, dilatation of the glandular acini and retention of the products of the secretion in the glandular cul-de-sacs.

The causes are: Abuse or privation of genital excitement, masturbation, prolonged or interrupted coït, stricture (aseptic) of the urethra, hypertrophy of the gland. Nearly all the cases that have become secondarily aseptic were consecutive to blenorrhagia.

Out of forty-six personal cases, minutely recorded by Dr. Le Fur, thirty-eight had a gonorrhœal history, fifteen had orchitis; five, an abscess of the prostate; twenty, large strictures; one, phimosis; while the cause was attributed to catheterism in five cases, and urethral injections in four cases.

The symptoms of chronic prostatitis are frequently obscure and attenuated. Pain is generally slight, vague, and diffuse. It is only in exceptional cases that it becomes violent, giving the sensation of a cut or a tear; in the majority of cases it consists in a sensation of weight, shooting pains in the perineum, irradiating to the anus, the inguinal regions, the back; but very frequently no pain or trouble is complained of.

The troubles of micturating were also very variable; in thirteen of the forty-six cases they were absent, but in the majority of cases frequency, both diurnal and nocturnal, of micturition was observed, and in twelve cases difficulty was experienced, especially in the morning; the patients had to wait more or less for the flow. Acute retention of urine was noticed in six cases, and in fourteen cases the urine was clouded from pus and microbes. In fourteen cases erections were frequent, especially at night, and spermatorrhœa and prostatorrhœa were observed in three cases.

The diagnosis of chronic prostatitis is generally easy to make by the method recommended by Dr. Le Fur. An experiment should be made first with three glasses to find and collect the filaments of urethritis (first glass), and to confirm the existence of more abundant filaments in the second and third glasses (a good sign of prostatitis). Examination by the rectum should then be made, the finger protected by an india-rubber cap. By this means the prostate and the seminal vesical are examined and massed; in this way the prostatic liquid can be collected directly from the meatus, or the urine after massage of the gland, containing the prostatic secretions; a macroscopic examination should be made at first and afterwards a microscopic examination, by which exact information will be obtained on the physiological and pathological condition of the gland. However, chronic prostatitis can be confounded with other affections; it can simulate syphilis, tuberculosis of the prostate, or a renal affection, and is frequently complicated with stricture.

Treatment.—The treatment of chronic prostatitis consists essentially in massage, digital or with an electric masseur invented by M. Le Fur; large dilatation and irrigation. The bougies should be very large (60, 70, and even 80 Béniqué). The irrigations should be done with a solution of nitrate of silver (1:1,000), and give excellent results. However, if the dilatation cannot exceed 45 or 55 Béniqué, urethrotomy should be performed, which always succeeds. Perineal prostatectomy constitutes exceptional treatment. The condition of the intestines should be looked after, as constipation aggravates the symptoms, and is not infrequently a cause of chronic prostatitis.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, August 19th, 1905.

THE MODERN METHOD OF TREATMENT BY TUBERCULIN.

THE *Deutsch. Med. Zeit.*, No. 64, has a reference to a paper on this subject by Dr. A. Feldt. The leading lines of the treatment are, according to the author, (1) very slow augmentation of dose and even then when the dose hitherto employed has caused no reaction; (2) diminution of the dose when the reaction from any specified dose has ceased to appear; (3) sufficiently long interval between the individual injections; (4) the utmost possible avoidance of severe general reaction with more or less grave symptoms. As transient immunity to tuberculin is very easily set up, long pauses should be made in the treatment now and again, after which, if the patient is not cured, reaction generally takes place to a dose much smaller than the one employed in the previous stage. A patient who will not react to a c.cgrm. several months after the last course may be looked upon as cured.

When, therefore, tuberculin has found a place in sanatoria and patients have been passed on from these to country residence for treatment in the country, it is plainly indicated that they should not be treated expectantly or with guaiacol, but should continue the tuberculin treatment. The commencement of a tuberculin course is contra-indicated after hæmoptysis, and with any considerable tendency to hæmorrhage. It is only relatively contra-indicated, however, in feverish cases and patients going about. Patients going about are unsuited for the treatment only when external circumstances—mental capacity or lack of education—do not allow of sufficient self-observation. The quintessence of modern views on tuberculin as they are crystallised amongst specialists in this branch are formulated thus: Tuberculin is a remedy to be often avoided, but which should be used at times, a remedy of incalculable value, which has at times been discredited by misuse, but which will in the future be perfected, but must never be forced. Its employment demands much more than the possession of a subcutaneous injection syringe and a table of doses.

No. 63 has an article by W. Reichmann on

The Treatment of Round Ulcer of the Stomach by Fasting.

Probably more medical men employ fasting as part of the treatment of these cases of ulcer of the stomach, but few probably consider it the most important agent. The author says that pain and hæmorrhage frequently persist or return after the use of even the most approved remedies. Under such circumstances he looks upon complete abstinence from food and drink at least by the mouth as the most effective method of treatment.

Before all, he enjoins absolute rest in bed. The patient is not only forbidden food and drink, but he must not even swallow his saliva. To avoid the feeling of dryness in the throat he is allowed to gargle frequently, and nourishment and the needful liquid are to be given by enemata. First of all, for a day or maybe two, in order to induce tolerance on the part of the bowel, only plain water is given in small quantities, not more than 5 ozs. or 6 ozs.; or salt or a small quantity of opium may be added. Later on 5 ozs. of broth may be given, to which are added two raw eggs, and ½ drachm of salt. Two to 3 drachms of grape sugar may be added, and a dessertspoonful of brandy or a tablespoonful of strong wine. In addition to the above, in order to keep down peristalsis, 3 to 8 drops of tr. opii may be added. The enema may be given twice or three times in the twenty-four hours.

Such a diet is naturally insufficient, but considering the absolute rest and the small amount of force expended, it may be made to serve for from ten to fifteen days. The treatment is rarely called for for a longer period, and the pain generally disappears after two or three days' abstinence.

It must be borne in mind, however, that this method of treatment has its disadvantages, as neurasthenic patients do not bear fasting, and it sometimes leads to great prostration and even fainting attacks. These disturbances may be so great that the plan must be discontinued.

Another unfortunate symptom that may come on is parotitis, which the author has seen three times. It is supposed to arise from collection of a pathogenic microbe in the mouth and should be guarded against by careful disinfection.

He recommends that the fasting treatment should not be commenced until the usual remedies have been tried and have failed.

Ulcus Ventriculi and Hyperacidity of the Stomach: their Treatment by Olive Oil.

The same journal contains a reference to a paper by Dr. A. Koehler, of Teplitz, on the above subject. He employed the oil treatment in cases of both organic and spastic stenosis of the pylorus and duodenum, and their sequelæ—dilatation of the stomach. The results were favourable. Whilst the oil arrested spasms and lessened secretion, and therefore the hyperacidity accompanying ulcer of the pylorus, it had also an extremely favourable effect in inoperable carcinomatous ulcers of the stomach.

In many cases, however, the treatment was not well borne, owing to the almost invincible repugnance some have to swallowing crude oil. For such cases, he devised sterilised gelatine capsules containing three and five grammes respectively, so that ten capsules of five grammes each corresponded to three tablespoonfuls of oil. One advantage of this method of administration was that all the medicine reached the right spot for local action.

Austria.

[From our own Correspondent.]

Vienna, August 19th, 1905.

Croatia and its Health Department.

The following may be interesting to English practitioners who, according to report, are complaining bitterly of the waning profession. A comparison with Croatia, however, has to be taken with many modifications. Salaries are small, but domestic expenses are correspondingly low. It need not be repeated that the greater number of medical men in Austria are under Government control. Croatia, for instance, is a principality of Austria and closely connected with Hungary, though perfectly distinct in its political government. The health department is therefore under the authority of the Croatian Government, which is, first of all, presided over by a proto medicus, under him a technical adviser, with a president of the county sections. These, according to Government authority with official classifications are all placed in the sixth rank. Coming after these officials is a medical secretary, with a large number of promising young men on his staff. He is placed in the seventh rank of medical merit. We come now to the workers of the medical health department, who have recently had a grievance to ventilate, owing to these classes having been divided between eight and ten in merit. Croatia contains 2,380,000 inhabitants, who are divided into eight "komitates," or communes, with a "komitatsfisikus" belonging to the eighth rank of merit. Again, each of these "komitates" has ten districts, with a medical man to each district. It is amongst this class of district men where the greatest discontent exists, owing to some of them being placed in the ninth rank, while others equally good are placed in the tenth rank. The cry has gone forth that it is degrading to the profession, and that these district doctors should be raised to their former position.

The value of this rank may now be estimated when we begin to consider salaries. The "bezirksaerzte," belonging to the tenth class, have 2,000 to 2,200 kronen per annum, equal to £80 to £88 per annum, while those of the ninth rank have 2,600 to 2,900 kronen, with the addition of 300 to 400 kronen for residence. This may give the reader an idea how the health department is conducted, although there are a number of other medical officers in more subordinate positions who conduct parishes and smaller divisions with a salary of 14 to 20 kronen. In these large districts there is another set of public officers, but not belonging to the same department, and whose duties are closely allied to them in the same districts. Properly speaking, the latter may be called parish doctors. Although having different degrees, they have each their appropriate duties, often coming in conflict with the health department. The private practitioner here is almost a negative quantity. This officialism has its advantages, as old-age pensions, though small, are provided for the old and infirm doctors.

Difference between Normal and Immune Agglutinin.

Landsteiner and Mathias, at the Pathological Institute, have been endeavouring to distinguish the relationship between the normal serum and the immunised serum. These two are generally recognised as one and the same, although Reisenberg, Gruber, and Volk have disputed their similarity. According to Landsteiner's experiments, the splitting of the union in the hæmaglutinin and blood corpuscles is very different, as the immunised agglutinin is much more difficult to separate than the normal agglutinin. The clumping of the blood corpuscles with the normal serum can be broken up by simply warming, while the immunised clumping requires sodium chloride and as strong heat to break it up.

THEORY OF BIOLOGICAL RAYS.

Schlichta has advanced another theory, or rather attempts to confirm many others, that the intracutaneous injection of different substances, such as alkalies and acids in specific doses will produce tissue changes of a pathological nature identical with the rays emanating from radium and the Röntgen machine. The erosive power of the rays may be equal in result, but he is still unable to explain a series of characteristic operations, which have less healing power under the use of the injections than those of the rays themselves.

Operating Theatres.

NORTH-WEST LONDON HOSPITAL.

CASE OF PYÆMIA AND MIDDLE EAR DISEASE.—Mr. M. COLLIER demonstrated a case of middle-ear disease having points of peculiar interest. It was one of chronic mastoid suppuration followed by general pyæmia. The patient was a woman, æt. 68, who was admitted to the hospital suffering from a large abscess in the left axilla following an attack of pain in the left ear, which had previously discharged for many years. The patient stated that she had suffered from this discharge for a great many years. At long intervals attacks of pain had occurred in the ear, confining her to the house or bed for several days. The pain usually subsided following a free discharge. She said that ten days before admission she had had an acute attack of pain in the left ear with pain and tenderness behind the ear; this had to a large extent subsided, and was followed by pain and tenderness in the left axilla, for which she sought admission. On admission the woman was seen to be of spare build, looking very much older than her years, and she had a sallow yellow complexion. There was an offensive copious discharge from the left ear, but no tenderness of the mastoid, no œdema of the tissues in the neck, no definite eye symptoms, and no paresis; the lungs and heart were apparently unaffected, and there was no abdominal swelling or tenderness. The swelling in the left axilla had evidently suppurated. The temperature was slightly raised. The swelling in the axilla was opened on the next day, and tonic and supporting treatment employed. On the evacuation of the contents of the abscess, the local condition quickly improved. On the tenth day after admission a swelling appeared in the right lumbar region followed by marked evening rise of temperature. This quickly suppurated, and was opened and drained. A few days after the right knee-joint began to swell, and this was accompanied by pain and tenderness, and fluctuation; the passage of a hypodermic needle revealed thin pus; the knee-joint was then freely opened and drained; unfortunately the condition of the right knee-joint was followed by pain and tenderness in the right shoulder-joint. On pus being diagnosed this joint was opened freely and drained. The patient's vitality all through these various procedures appeared quite inconsistent with her wretched general condition. The temperature all through rose but slightly above the normal, and the woman died, worn out by suppuration, within the following fortnight. Mr. Collier said that in reviewing the history and facts of the case at first the association of the ear trouble with general pyæmia was a matter of speculation. There was no definite evidence of involvement of the lateral sinus; the absence of cerebral symptoms did not support the theory of infection from the tympanic cavity. The fact of an abscess appearing in the axilla associated with recent ear suppuration need not be looked upon in the relation of cause and effect; the question whether the mastoid should have been opened on admission to hospital had been discussed; in the absence of a positive diagnosis it was deemed wiser to treat the ear on general principles and to open the axillary abscess and get the patient in a better state of health before attacking the mastoid. The subsequent course of events left grounds for doubt whether the pyæmia was not due to the ear trouble; it was possible, however, that pyæmia may have followed and been secondary to the axillary abscess and the subsequent pyæmic infection of the joint again secondary to this. In the unfortunate absence of a postmortem examination, the true facts of the case could not be ascertained.

ACUTE SUPPURATION OF BOTH TYMPANIC CAVITIES FOLLOWING DIVING IN THE SEA.—The same surgeon operated on a case of acute middle-ear suppuration following diving. The patient, a young man, æt. 29, after diving in the sea from a height, was seized the same evening with pain and deafness in both ears. He was attended by a local practitioner, and after three days of intense agony a discharge appeared from the right meatus followed by cessation of the acute symptoms in that ear. The left ear was more obstinate to treatment, the pain and tenderness increasing with a gradual exacerbation of all the symptoms. The man was sent up to town and admitted into the North-West London Hospital. On admission the temperature was 103·5°, there was great agony located in and behind the left ear; the auditory canal was so swollen that the drum could not be seen. The anterior wall of the mastoid antrum was bulging in to the auditory canal, and the whole of the tissues in a state of œdema. Under an anæsthetic, Mr. Collier introduced a fine curved tenotomy knife into the auditory canal, incised the drum at its posterior and lower segment as well as the tissues forming the anterior wall of the mastoid antrum. This was followed immediately by a copious discharge of pus, and much relief to the symptoms. The interest of the case, Mr. Collier said, centred on the cause. He pointed out that the introduction of sea-water into the auditory canal is often followed by acute suppuration of the mastoid cavity without previous affection of the mastoid contents, and the question of how and why this takes place is not altogether apparent; whether a direct infection occurs *via* the auditory canal or *via* the Eustachian tube is a matter of speculation. The difficulty of infecting the tympanic cavity through a whole and sound membrane could not, he thought, be lightly discarded. A more rational view of the causation, he said, might be that water enters the tympanic cavity *via* the Eustachian tube, having entered the nose or mouth during immersion. The intensity of the symptoms in these cases he remarked could not be explained by the mere pressure and injury caused by the condensed air in the auditory canal. Mr. Collier also said that prompt incision of the drum in these cases would save much misery and probably in many cases complete loss of hearing.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 23, 1905.

POOR LAW COMMISSION.

It is good news to everyone who has considered the subject that the Government propose to appoint a Royal Commission to inquire into the working of the Poor Laws; for the administration of the 1834 Act and the subsequent measures that have been committed to the management of the guardians need thorough overhauling in the light of seventy years' experience. Medical men, both as citizens and as professional men, have much concern with the means by which the social wrecks and derelicts of their country are dealt with, and a large number of doctors are employed in one capacity or another as servants of the boards of guardians. These latter will be intimately affected by any changes that are proposed, but from the national standpoint their colleagues will be no less interested, although their own positions will not be involved. It is much to be regretted that a step of such momentous importance was decided on at a period of the Session which did not admit of its full discussion, and that the terms of reference and the composition of the Commission could not be announced till after Parliament had risen. In the first place we may be allowed to express the hope that the members of the Commission will not be appointed on political grounds, as the one thing the average politician knows least about and cares least about is, if we except the cause of public health, the business of the Poor Law. The local doings of the guardians are considered unworthy of the notice of men whose palates crave for the sensations provided by African intrigues and storms in Asiatic tea-cups. But as affecting the national health and prosperity, on which all foreign relations ultimately depend, there are few matters of more vital moment than the prevention of pauperism among the working classes and the maintenance of that abounding self-sufficiency on which the edifice of the British Empire has been built up. The able-bodied pauper is a disgrace to any civilised country. and that his existence should be tolerated in the workhouses of the country bespeaks a lamentable hiatus in the machinery that caters for the poor; he may be unfortunate, in which case provision for his needs should be made in other ways than at present are available; he may be vicious or idle, in which case he is no fit associate for the worthy, worn-out worker who is passing the evening of his days under care which he well deserves. The recognition and certification of men as able-bodied is essentially a medical duty, and for this and many other cogent reasons it is necessary that the medical profession should be well represented on the Commission. Expert advice, too, is greatly needed with regard to infirmaries, which constitute an integral part of the workhouse equipment. We have often had to draw attention to the inadequate staffing of some of these infirmaries, and it would be well that a definite minimum number of nurses should be assigned to a definite number of patients. The treatment of the sick poor should doubtless be conducted on economical lines, but it is more than a tiresome addendum to the guardians' work, to the medical man, at least, it appears as a sacred duty. Another subject we should like to see definitely taken in hand by the Commission —namely, the utilisation of the clinical material of the infirmaries for the instruction of students and post-graduate classes. It is a revelation to many medical men whose knowledge of disease has been gathered in general hospitals to find in the wards of infirmaries crowds of sufferers from chronic maladies which they had been accustomed to regard as clinical curiosities. These infirmaries present vast unworked fields for diligent and enthusiastic young men, and not only might such men add greatly to their own clinical knowledge by studying in infirmary wards, but they might work out in detail many of the theoretical suggestions that they had learned from their teachers —to the great advantage both of the patients themselves and humanity in general. If some scheme could be devised by which the administrative work of the infirmaries remained in the hands of the superintendent and his subordinates, while the clinical care and treatment of the patients devolved largely on recently qualified assistants, it might be possible that every medical student had the opportunity of holding a resident appointment after graduation. There is a further matter that we hope will come within the terms of reference to the Commission, as it presents one of the most glaring anomalies of Poor Law administration; we mean the carrying out of the Vaccination Acts. Vaccination is peculiarly and entirely a matter of disease-prevention, and should belong to the province of the sanitary authority who are charged with the care of the health of the community. Administered by the boards of guardians as these Acts now are, the utmost confusion reigns in small-pox outbreaks when it is the duty of one authority to isolate patients and of another to vaccinate contacts. Moreover, in districts in which anti-vaccinators are prominent, the return of guardians is made to hinge on their support of an opposition to vaccination, a matter which is easily arranged by an interested clique in elections which excite so little interest as do those of the guardians. A much broader view is taken of the qualities of a town councillor, and his election is determined by other circumstances. For many reasons, then, we trust that a strong medical element will be found in the composition of the Royal Commission.

THE CAUSE OF LEPROSY.

Recent advances in bacteriology have so completely modified our ideas of the causes of many diseases that one scarcely expects to find any survival of a belief in those etiological factors of disease which satisfied our predecessors of two hundred years ago. From the fifth century down to as late as the end of the fifteenth century leprosy was a common disease in Ireland, as is attested by the numerous leper hospitals or houses that were established throughout the country. The leper-house at Waterford, which was confirmed to the poor of the city by a charter of King John in the year 1212, continued in use as a leper-house till 1740, when it was converted into a public infirmary, and is at present used as the Waterford County Infirmary. On May 15th, 1903, Mr. Jonathan Hutchinson, at a meeting of the Polyclinic, strongly advocated the view which he had previously put forward, that "leprosy is in some way connected with the eating of fish in an uncooked state—and often decomposing state." And, further, "it is suspected that the fish food of this kind, uncooked, may either carry the bacillus itself, or may be the stimulant which excites it to action." In this connection the following extract from Boate's "Natural History of Ireland," is of interest:—"The rickets are of late very rife in Ireland, where a few years ago unknown; so, on the contrary, it hath been almost quite freed from another disease, one of the very worst and miserablist in the world, namely, the leprosy, which in former times used to be very common there, especially in the province of Munster, the which therefore was filled with hospitals, expressly built for to receive and keep the leprous persons. But many years since Ireland has been almost quite freed from this horrible and loathsome disease, and as few leprous persons are now found there as in any other country in the world; so that the hospitals erected for their use having stood empty a long time, at length quite decayed and come to nothing. The cause of this change is not so obscure nor unknown as it is in most other changes of that nature. For that this sickness was so general in Ireland, did not come by any peculiar defect in the land or in the air, but merely through the fault and foul gluttony of the inhabitants, in the successive devouring of unwholesome salmons. The common report in Ireland is, that boiled salmons eaten hot out of the kettle in great quantity, bring this disease, and used to be the cause why it was so common; and some famous authors have not stuck to relate as much for a truth. But that is a fable, and salmons have not that evil quality, which way soever they be eaten and prepared, but when they are eaten out of season, which is in the latter end of the year, after they have cast their spawn, upon which they do not only grow very weak and flaggy, but so unwholesome, that over their whole body they break out in very filthy spots, just like a scald man's head, so as it would loath any man to see them; nevertheless, the Irish, a nation extremely barbarous in all the parts of their life, did use to take them in that very season, as well as at any other time of the year, and to eat them in very great abundance, as easily they might, every river and rivulet in most parts being very full of them, and by that means that horrible disease became to be so common amongst them. But the English having once gotten the command of the whole country into their hands, made very severe laws against the taking of salmons in that unwholesome season, and saw them carefully observed, whereby hindering those barbarians against their will to feed on that poisonous meat, they were the cause that that woful sickness, which used so mightily to reign amongst them, hath in time been almost quite abolished, which great benefit, with so many others, that hateful people hath rewarded with seeking utterly to exterminate their benefactors." Gerard Boate, was a Dutchman, and with his brother, Arnold, was educated at Leyden. Subsequently he practised physic in London, but came to Ireland on the invitation of Archbishop Usher. Boate was appointed Physician to the State, and died in office shortly after his appointment, on January 19th, 1649. The book, from which the above quotation is taken was written before he came to Ireland, though not published till after his death—1652. The book was re-issued in Dublin in 1755, and it is from this edition that the quotation is taken. Boate is not looked on by subsequent writers as a reliable authority in matters of Irish history, and we fear that his explanation of the cause of leprosy will not find much more support among the profession than will his appreciation of our countrymen find among his modern Irish readers.

HERACLITUS, 1905.

The philosopher who at the end of the world puts the finishing touches to the history of thought is likely to find his mind impressed more by the essential sameness of human speculation than by its apparent variety. It is, on the whole, more true that there is nothing new under the sun, as set down by the Hebrew aphorist, than that invention is endless, and it is a passing tribute to human ingenuity that with the same materials it is able to fashion and refashion such a puzzling multiplicity of figures. The history of civilized peoples is, allowing for time, circumstances, and national idiosyncrasy, merely a repetition of the same phenomena in different settings, and this is no less true in the domain of thought than in any other department of the life of an organised polity. The process and the steps by which development proceeds are the same; it is only the local colour that varies. Moreover, since thought has become capable of embalmment in literature, each generation of successive states has been able to profit by the experiences of its forbears; in a word, to begin where they have left off. But though fresh factors are brought into the working of the problem the principle of resolution is much the same as it was before their introduction. Modern science, it is fashionable to consider, is a new feature in the history of the world, and it would ill become medical men to neglect those principles of thought which have rendered modern scientific achievement possible, but the fact remains that, apart from its practical bearings, scientific discovery and research tend rather to exemplify and corroborate, and lend exactness to the theories of the philosophers of ages past than to create new modes of thought or essentially novel speculation. If, as Protagoras maintained, man is the measure of all things, all things can only be measured by man's mind, and as man's mind in finite, it is not surprising to find him continually arranging and rearranging his conceptions of things in similar circles in different ages. The presidential address at the annual meeting of the British Association is generally looked to to provide a broad sketch of the position that scientific thought has reached, and Professor Darwin's address at Cape Town this year fully maintains the high standard attained by his predecessors. It was perhaps natural, as expressing in concrete form the advance of four centuries of acquired knowledge, that the lecturer should have instanced the shortening of the journey to the Cape, which took Bartholomew Diaz sixteen months of battering in a crazy brig, and Professor Darwin and his colleagues a fortnight's lounging in the saloons and smoking-rooms of a 13,000-ton ocean steamer; and that from this striking exemplification of the power man had acquired over nature he should have proceeded to dwell on the astonishing rapidity with which new marvels of discovery take each other's place in the gaze of mankind with each succeeding year. But from this introduction, Professor Darwin proceeded to plunge into the less sure region of speculation as to the future, basing his forecast on the probable continuance of action of the same causes that have operated in the past. That speculation forcibly led to the conclusion that no elements are eternal, for in spite of all that was taught and held till a few years ago, the elements have not proved stable in the past. Only those that are comparatively well adapted to the conditions of the earth are capable of survival, the others arranging and re-arranging their component elections till some new and more stable product results from their activity. The atom is no longer conceived of as being indivisible, but on the contrary is composed of separate corpuscles (or electrons), which may be described as particles of negative electricity, and these electrons, though acting with mutual repulsion towards each other, are preserved from disruption by some force such as that provided by a positive electric charge. But even the stability thus ensured is only a comparative quantity, for the electrons must eventually dissociate and help towards the formation of new atoms, even though their association in the original atom has been maintained during thousands of revolutions in the same orbit. In radium and the associated elements possessing very complex atoms this breaking up and spontaneous rearrangement of electrons can be actually observed, and thus transmutation of elements is practically demonstrable. It follows, therefore, that the resulting relative stability of certain atoms and the relative instability of others is due to the operation of the Darwinian force—natural selection. A safe parallel to this perpetual mutation of the components of the atom is presented by the political constitution and mutability of states, which rise, last, and fall according to the perfection of their adaptation to surrounding conditions, and analogy also tends to overthrow any idea of permanence or fixity in animal species. Thus species becoming evolved beyond a certain point either rapidly degenerate or become extinct, according to the circumstances of their environment. Such then is the doctrine of the scientific philosopher of 1905 A.D., and it is difficult to see how it differs essentially from that propounded by Heraclitus in 500 B.C. Darwin is certainly as lucid as Heraclitus was obscure, and Darwin is exact where Heraclitus was mysterious. But after all, we come back to the *panta rei* as the be-all and end-all of the manner of the world; matter organic and inorganic, existing only in transition; the universe in a state of flux. The ultimate essence of all things which Heraclitus looked upon as "fire," we, after two and a half thousand years, designate "electricity," and it may as well be admitted that we know about as little of the one as he did of the other. What we term the struggle for existence and the survival of the fittest he spoke of as contradiction and strife constituting the essence of existence. Latter-day scientific pronouncements read more like revised editions of the *peri phudeos* of the old Ephesian philosopher, than as dazzling original creations by modern geniuses.

Notes on Current Topics.

Happiness as an Economic Item.

THE commercial and economic value of happiness has been the subject of discussion in the *Business Magazine* by the eminent psychologist, Professor Walter Dill Scott, of North Western University. The writer tells us that he has found by repeated laboratory tests that a man's ability to put forth effort is dependent upon many factors other than his general physical condition. Some athletes have been found to double their strength under coaching. When a man is trying his best he still may not be putting forth more than half his possible strength Another powerful modifying factor in the availability of physical strength is "the general condition of the mind of the person tested." Professor Scott finds that every element of pain reduces the strength, and every element of pleasure increases it. Factory hands can produce more in a day under pleasant conditions than when under unpleasant ones. Pain, the writer tells us, lowers the vitality, affecting, as it does, the functional activity of the heart and lungs, and thus of the whole circulation; and, consequently, of the nutrition of the whole body which depends thereon. "These things go far to explain the sudden demoralisation of a football team which for a time has been the equal of its successful opponent." Of course, he might have added examples from the various occupations of ordinary life, as well as from the field of sport. It is universal experience that happiness stimulates both mind and muscle to keener and more rapid and more effective activity. It originates new devices, mechanically; and new diplomatic schemes, politically; and assuredly promotes cordially united effort towards the attainment of desirable consummations. In the exercise of the available powers of the office as well as of the team, of the mechanic as well as of the diplomatist, in the hall of council and on the field of battle, the most optimistic spirit accomplishes the best results.

Hospital Sunday Fund.

It is with peculiar satisfaction that we read that the Hospital Sunday Fund have decided to make a move in the matter of the overcrowding of the out-patients' departments of the London hospitals. This glaring abuse of the hospital funds has been increasing in magnitude every year, encouraged unfortunately by many hospital managers, who like to boast of the extent of their work by referring to the number of cases treated, irrespective of whether the patients were or were not fit subjects for charitable relief. The Hospital Sunday Fund have informed the secretaries of the eighty London hospitals that have out-patient departments that the increase in the number of patients is detrimental to the welfare of both hospitals and patients. Many suffer only from trivial complaints, and they only burden the funds and take up the time of the staff which should be devoted to the more serious cases. The Sunday Fund do no more than invite the opinions of the hospital boards on the subject, and, if these agree with their own, any suggestions for a remedy. They would be glad of an answer before the end of the financial year. Now the Sunday, though only one of the Funds, are a powerful and influential body, and what is more to the immediate point, are in possession of an income of £75,000, which they can distribute at will. No hospital can, therefore, afford to disregard their representations, and it may be well that this step tentatively taken will lead to that reform in the out-patient departments which has been so long and urgently pressed for by medical men. No doubt the Fund will encounter difficulties in the way, but we hope they will have the courage of their opinions, and if they succeed in remedying the abuses they are preparing to tackle, they will deserve the congratulations of the profession.

Linnæus and His Gout.

The student of the history of Botany, if a genuine devotee—as every student of that fascinating science is so likely to become—values Sweden chiefly as the land of Linnæus. And one of the items of the folk-lore medicine of that country was largely used by the immortal botanist on his own person. He tells us that he was cured of a violently acute attack of gout by eating wood-strawberries. Ever afterwards, it is almost superfluous to add, he consumed during the season as many as his digestive organs could dispose of. Like every genius, he was greatly influenced by the agencies of the emotions. He had on one occasion been tightly gripped in the vice-like embrace of gout, and was disposed of in the regulation costume of chairs, cushions, pads, and bandages. A sympathetic Providence just then sent a former pupil home from Canada loaded with new plants, with which he at once hastened to his almost adored master. When he entered the room where the latter sat groaning, and laid his offering before him, the overjoyed enthusiast at once stood up, and continued to walk about while examining the valued specimens! Readers will, of course, remember how the "strawberry cure" of gout was boomed some five or six years ago as a *new* clinical discovery. Not an unprecedented item in the history of invention by any means!

The C.E.T.S. and its Methods.

Any comments that we may make on the methods of the Church of England Temperance Society will not be taken to indicate a spirit of hostility to a society which in its aims, and hitherto in most of its methods, has deserved the support of all social reformers. There is no class in the community that of late years has done more to draw attention to the evils of alcohol than the medical profession, and if any evidence were needed as to current opinion on the subject we might mention the recent petition forwarded to the President of the Board of Education in favour of teaching hygiene and temperance in elementary schools, a petition which was got up by leaders of the medical profession and signed by 15,000 practitioners. But we see from an appeal in the daily Press that the Church of England Temperance Society, through its branch at Norwich, has embarked on a system of treatment by private methods, and that it is now touting for patients to fill its "home." Anything more degrading to the Society or insulting to the profession it is difficult to conceive. The Society, before making this fatal mistake in policy, would have done well to take into their confidence approved leaders of medical thought, and to have been guided by their advice as to the method to be pursued. The result would have been a foregone conclusion. Secret treatments and secret remedies there have been and are without number, to cure alcoholism and all the diseases under the sun; but they have only a long record of failure, generally associated with heartless frauds, to show. Medicine is a catholic and honest profession, and has ever shown itself as willing to approve what is good and sound, as to reject the worthless and underhand. Mr. Phillips, who signs the letter of appeal, will have only himself to thank if he finds himself in the future in a very uncomfortable position with regard to this "method of treatment."

The Vicar as Healer.

CERTAIN of the less well-informed members of the Church still seem to hanker after the ancient prerogative of the Apostles in the healing of the sick, though it may be gratefully acknowledged that the bulk of churchmen and of other religious sects recognise that the function of curing the body is best performed by those who have acquired some knowledge of disease and of remedies. The modern clergyman, too, must have reason to be thankful that the task of attendance on sick people is performed by others than himself, as his own duties are sufficiently onerous and exacting without the labour of watching medically over the sick of his flock being added to them. Incidentally, too, it may be to the advantage of the patient that the present arrangement prevails. With the Vicar of Brigstock, however, it would appear to be otherwise than with most of his brethren. It seems that the countryside in and about Kettering has been thrown into a state of apprehension by the occurrence at Irthlingborough of several cases of "spotted fever," as the newspapers delight to call cerebro-spinal meningitis, and their alarm has been justified to a certain extent by a crop of cases appearing in a farmhouse at a village called Grafton Underwood. Following on this outbreak came a case of illness in Brigstock which interested the Vicar greatly, so much so indeed that he appears to have assumed the rôle not only of physician but of medical officer of health, for, with a boldness born of ignorance, he is reported in the *Morning Leader* of August 15th to have communicated with the Local Government Board. A happy ending came about by the patient in question recovering, though through whose instrumentality the report does not state specifically. The Vicar is naturally elated, and goes about publicly boasting that he has cured the sufferer of cerebro-spinal meningitis. The paper naïvely adds: "But for the flat denial of the medical authorities that the case was one of spotted fever, the close proximity of the two places would have afforded a likely explanation of the present outbreak." The Vicar, at all events, will now be free to resume his own avocations.

Death of an Amœba.

THE amœba loomed largely over the mental horizon of most of us in the days of our physiological probation. And there has always been attached thereto an interest of mystery unsolved. From one point of view, at least, this microscopic specimen of animated nature seemed to possess a definite physical claim to immortality. Multiplying its own image by a simple process of splitting itself into two halves, it thus continues its career through time and space in such a way as to leave it quite impossible to say where the line of definition between parent and offspring can be drawn with anything like logical precision. Mr. Edwin Linton has contributed to *Science* what we believe to be a pioneer observation—"The Death of an Amœba," in one of its parts. He had been observing one, which seemed rather more highly charged than usual with granules, when on the point of undergoing the process of procreation by fission. It split, in an approximately normal fashion, but one of the resulting parts possessed less protoplasm and more granules than the other, Then the more protoplasmic half moved quietly away to live its blameless life, but the more granular one began to show symptoms of internal anxiety. It assumed an irregularly spherical shape; it gave the observer the idea of appearing as if the contents were too much for the skin, and—in another moment, all that was left was a cluster of granules without connecting material, and without any sign of animation whatever. The entire process occupied about eight minutes. The observation is an epoch-making one; it is a primary record, and goes to show that the immortality of the amœba cannot henceforward be regarded as an essential article of biological faith.

Suicide after Operation.

AN incident is reported in the *Odessa Novosti*, which, if true, is full of pathos and interest for medical men. It appears that a Dr. C. Polyankoff was driving past a farm when a poor woman ran out of a cottage and begged him to see her child, who was very ill. The doctor did so, and after examining the patient came to the conclusion that he had diphtheria, and advised that he should be removed to the town hospital. The parents, who seem to have been deeply attached to the child, refused to part with him; and Dr. Polyankoff was compelled to do the best he could for him in the rude cottage. Calling next day, he found that it was necessary to perform an operation—presumably tracheotomy—and single-handed he essayed to carry it out. Something, however, went wrong during its performance, and though he gave up his engagements and remained with the child for some time he saw that it was impossible to save the patient's life. This unhappy occurrence so much affected his mind that he burst into tears, and reproached himself with being a murderer. He then hastily wrote a note, and putting it under the ink-bottle, asked the mother for a drink of water. No sooner had she left the room to fetch it than the report of a revolver was heard, and on hurrying back she found Dr. Polyankoff dead with a bullet-wound in his temple. The note ran as follows: "Pardon a young doctor his involuntary error, by which he has deprived you of your child. I have expiated my crime. May my death serve to comfort you for the grief that has befallen you." It is sad to think of a young fellow of such obviously good parts destroying his life in consequence of an error of judgment.

The Teaching of Sexology.

IN a contribution to the *Pacific Medical Journal* of July, 1905, which bears the title of "The Medico-Legal Consideration of Perverts and Inverts," Dr. R. W. Shufeldt (retired Major, U.S.A. Medical Department) pleads strongly for the desirability of the recognition and systematic teaching of the science of sexology. He refers, forcibly and feelingly, to "the case of the unhappy Miss Ida C. Craddock, a teacher in sexology, who was driven to suicide through the outrageous injustice of the law courts, and the persistent prosecution of the public censor of obscene literature." And this impression was originally stamped on the writer's mind by an indelible personal experience. Of this he tells us that: "Never was I so discourteously treated in the witness-chair in my life, where I sat as an expert in that lady's case, as I was by the senior or presiding judge in that farce of a trial. It was astounding and distressing to observe how utterly ignorant the judges were of the nature of the person on trial or of anything else that pertained to the subject." Major Shufeldt scouts the idea that the definitely clear scientific teaching of sexology would tend to the promotion of "vice." He tells all advocates of this view that they seem to be totally ignorant of the fact that at any time in the life of one who is a sufferer from any pronounced form of sexual abnormality, the abnormality is not communicable to others, either through infection or contagion. Further, that those who are psychically and sexually sound, and so constituted that they will remain so throughout life, are in no danger of being rendered otherwise, either by viewing art works of any description, or reading books on sex or sexual diseases—much less by associating with sexual perverts. While on our own part strongly disposed to draw the line—very sharply and tightly—at all *unnecessary* "association," from the fact that we are strong believers in the power, for culture and development, of the factors of idleness, "suggestion," and opportunity, we in the main agree with his view, and believe that in the case of healthy minds the seeds of "vice" fail to take life-supporting root when they fall on the rocky soil of moral sanity. And we are also strongly of the opinion that more definitely systematic teaching would tend to prune morbid curiosity, while it would most assuredly cut the ground from beneath the feet of the very numerous quacks who now depend on it for a —very substantial—source of nutrition.

Dr. Freyberger as an "Obvious" Expert.

MR. JOHN TROUTBECK, his Majesty's Coroner for Westminster, continues his ostentatious flouting of the main body of the medical profession by employing a so-called "expert" to give medical evidence. Recently the gentleman in question, Dr. Freyberger, has appeared as a witness in two asylum cases, in both of which a patient died from terrible injuries. As a matter of fact it does not need the self-assumed expertness and special training of a Freyberger to say when a person has received a mortal injury in the shape of a ruptured heart or liver. It may be noted that newspaper reporters appear to follow Dr. Freyberger's evidence with the utmost keenness, inasmuch as the public is being constantly regaled with choice bits of more or less medical knowledge hailing from that quarter. Such publicity, however, must perhaps be regarded as an unfortunate accident, inseparable from the office of Mr. Troutbeck and of his somewhat hybrid official, for we believe that neither Mr. Troutbeck nor the London County Council has any legal ground for appointing a special pathologist. So far as we can gather, Dr. Freyberger's chief justification for the post appears to be in furnishing newspaper reporters with ponderous statements of the obvious. Not long ago, for instance, a short lecture on the elastic function of the ribs in the protection of internal viscera was delivered in Court. We venture to assert that the ratepayers of Westminster would find it far less costly and more to their interest in other ways to insist upon the employment of general practitioners at inquests.

A Liquozone Testimonial.

IT will be within the recollection of readers that a Coroner's Court inquiry recently attributed a death to frequent doses of a proprietary preparation sold under the name of "Liquozone." It was shown that sulphurous acid was an active ingredient of the preparation, and that death was due to the irritant action of that drug. An accident of that kind, it might readily be supposed, would kill the patent medicine that killed the patient. The proprietors, however, evidently do not share that opinion, for they have started on a new phase of activity that has attracted the attention of the editor of *Truth*. Among new Liquozone testimonials is one by Mr. S. Rideal, D.Sc.Lond., F.I.C., who states that a 5 per cent. solution of sulphurous acid kills cultures of *bacillus typhosus* in five minutes, whereas sulphuric acid of similar strength takes a quarter of an hour. He states elsewhere that Liquozone is a perfectly safe preparation for adults (it was a child that was the subject of the inquest). This statement as to the innocuousness of the stuff we regard as absolutely misleading and dangerous. It is so serious a matter that, in our opinion, it demands the attention of the Senate of the University of London, from whom Mr. Rideal has obtained his degree in science. After all said and done, it is open for the proprietors of Liquozone to point out that evidence favourable to their preparation was given at the inquest by a well-known physician and lecturer in forensic medicine. Another testimonial has been furnished by Gordon Stables, M.D., late R.N.

Creator Recreatus.

The year of grace 1905 threatens to produce such a crop of spontaneous generators as is likely to be a serious menace to the public peace of mind. No sooner have the remarkable discoveries of Mr. Butler Burke ceased to be (a short) nine days' wonder, than we are faced with a new creator of life, Dr. Charles W. Littlefield. In the pages of *Harper's Weekly* he tells a thrilling story. Recognising that living beings must have originated ultimately from inorganic substances under certain primeval conditions, he set himself to reproduce as far as possible the *milieu* of the creation, and having provided all the accessories needful for the birth of life, sat down to watch. Twelve miniature oceans were represented by twelve prosaic tumblers of water, and into each were introduced the mineral compounds essential to the composition of animal and vegetable tissue. Next he added a drachm of carbon bisulphide to each of the miniature oceans—perhaps by way of smelling out any recalcitrant mermaids—and left the tumblers uncovered and exposed to a regular temperature of 75° to 80° Fahrenheit, each ocean being filled up with boiled water to supply the loss caused by evaporation. Here, then, we have all the materials of creation ready to hand, except perhaps that no darkness was provided to brood over the face of the deep tumblers. The accoucheur did not have long to wait before the portents of the coming birth appeared in the shape of crystals resembling "well-proportioned vegetation" in drops of water removed from the oceans and evaporated on glass-slides. These crystals were then set on plates, and surrounded by a moist atmosphere at between 75° and 80° Fahrenheit, when in twenty-eight days—hey, presto!—a number of microscopic plant and animal cells were found growing on the plate. As Charles Bertram would say: "Isn't it wonderful?" The extraordinary thing is that scientific men should have blundered along all these years without having thought of this simple plan of re-enacting the creation: if they had only studied Hamlet, they might have discovered the value of the method long ago. We now confidently await the resignation of the Archbishop of Canterbury, the disestablishment of the Church, and unqualified apologies from all leaders of religious thought.

Abuse of Sanitary Powers.

It is possible to have too much of a good thing, even of compulsory sanitation. Perhaps it might be well to say at once that superfluous or ill-grounded sanitation is alone meant. Thus amended the statement applies to the ridiculous counsels of perfection that are constantly being thrust upon long-suffering householders by unwise, over-zealous or corrupt sanitary authorities. In some notorious cases that have come to light the hapless ratepayer has been simply "bled white" by sanitary inspectors in league with builders and engineers. It is extremely hard to get at blackmailing of that sort, and the chief safeguard lies in the careful supervision of all subordinate reports as to sanitary defects submitted to the Medical Officer of Health, and by him to his local authority. A contemporary has recently given some glaring instances of persons living in the country who have been called upon, under various pains and penalties, to lay on the local water supply, in spite of the fact of their possessing excellent wells of their own. It cannot be too widely known that the local authorities have no power to act unless they can prove by bacteriological analysis or otherwise that the existing supply is impure. In other words, the order to adopt the public supply, unless supported by specific evidence of impurity, is grossly illegal, and can be resisted by the owner. In such cases the authorities appear to reckon on the ignorance of the man in the street of his own rights in relation to sanitary legislation.

Death caused by Yew Leaves.

The poisonous effects of yew leaves upon cattle are well known, and many instances of fatalities of the kind are on record. Human poisoning is practically unknown, chiefly because mankind is not given to indulging in food of that sort. A few days ago, however, an inmate of St. Andrew's Lunatic Asylum, Northampton, consumed a quantity of leaves unperceived by the attendants. He subsequently died, and at the inquest the sensible suggestion was made by the jury that all yew trees in the asylum grounds should be cut down. The occurrence is of interest. Doubtless instances of a similar kind could be discovered, and we should be glad to hear of any that may be known to our readers.

PERSONAL.

The King and Queen paid an unexpected visit to Ryde on Wednesday, the 9th inst., and inspected the Royal Isle of Wight County Hospital.

The foundation-stone of a new isolation hospital at Preston was laid by Dr. Brown, chairman of the Health Committee, on August 10th. It is expected to cost £20,000, and will be provided with two pavilions for scarlet fever, one for diphtheria, and one for typhoid fever patients. There are to be 56 beds.

Mr. A. Cameron Corbett, M.P., has notified the Lord Provost that he has agreed to purchase a part of Ardkingloss estate, and intends handing it over to the Glasgow Corporation. The extent of the land in question is 9,000 acres, and is finely situated between Loch Long and Loch Goil.

The Lord Chief Justice (Lord Alverstone), who has had a cottage hospital built at Shanklin, Isle of Wight, in memory of his only son, the late Hon. Arthur Webster, will formally open the building on Wednesday, September 20th next.

Under the will of the late Mr. Godfrey Ermen, Manchester receives a donation of £12,000 to the Children's Hospital. It is to be applied to providing a new dispensary and out-patients' department and will cover the cost, leaving the funds contributed by various helpers available for other objects of the appeal.

Miss Honan has presented a new operating theatre to the North Charitable Infirmary, Cork.

Sir Frederick Treves, G.C.V.O., will take the chair at the annual dinner of the London Hospital Medical College, on the opening day of the Winter Session, October 2nd.

Sir James Crichton-Browne, LL.D., F.R.S., will deliver the inaugural address at the commencement of the Winter Session at Charing Cross Hospital Medical School.

The London Homœopathic Hospital has just received a legacy of £250 bequeathed to it by the late Miss C. M. Petter, of Bournemouth.

Last week a donation of 100 francs was sent from the medical officers of the French Fleet to the funds of the Royal Portsmouth Hospital.

Dr. W. H. Clements, District Commissioner and Government Medical Officer of the Caicos Islands, has been appointed District Commissioner and Assistant Colonial Surgeon in the Toledo District of British Honduras.

Special Correspondence.

[from our own correspondent.

BELFAST.

Infant Mortality in Belfast. The Medical Inspector of the Local Government Board attended a meeting of the Public Health Committee of the Corparation last week, to confer on the subject of the excessively high infant mortality now prevailing in the city. He suggested to the Committee the desirability of issuing instructions regarding the feeding of infants, as was done on a former occasion with good results when the death-rate from diarrhœa and similar diseases was unwarrantably high. The Committee has adopted the suggestion. They have also taken steps to procure information regarding the deaths of children under five years of age, and one of the lady sanitary inspectors has been sent to inquire concerning the circumstances. She reports that most of the children are nursed out, that is, the mothers work out and leave the children with some one who is willing to take charge of them for a small consideration. They were nearly all bottle-fed, and seemed to have been ailing from birth. In only one case did they admit having used condensed milk.

Londonderry Asylum.—The report presented last week shows that during the past year there has been a decrease of one on the male side, and an increase of 14 on the female side, the total number of patients being now 512. The asylum is overcrowded by 116 patients.

Death of Dr. McMordie, Omagh.—Dr. David McMordie, a young medical man of great promise, died suddenly at Omagh on August 11th. He had suffered from two brief attacks of meningitis during the summer, but they seemed to have passed off entirely, and to have left no trace behind. Apparently, however, they were connected with some deep-seated trouble in the brain, which caused a sudden collapse. He had assisted at some operations at the County Tyrone Hospital on Thursday, and had gone to bed apparently in good health, but was found unconscious in the morning and died the same evening. Dr. McMordie was one of the most brilliant students of his time in the Royal University and in Queen's College, Belfast, and after graduation he acted as demonstrator of anatomy in the latter institution for some time. After a trip to India, and some experience as a resident medical officer in a large English hospital, he settled at Omagh two years ago, and soon made many friends. When at college he was deeply interested in the Literary and Scientific Society, and in the Students' Christian Union, and was elected President of the Medical Students' Association. His many fellow-students, now scattered over the world, will hear of his early death with very real and deep regret.

Correspondence.

THE PHYSIOLOGICAL BASIS OF NATIONAL STABILITY.

To the Editor of the Medical Press and Circular.

Sir,—The address of Dr. Carpenter on the "High Infantile Mortality Rate" and the letter signed by Henry Sewill on the "Physiological Basis of National Stability," which appeared in your last impression afford interesting reading when compared and assimilated. On the one hand we are informed that 75 per cent. of modern mothers are capable of feeding their babes with the food Nature has provided, but that scarcely any among the upper classes yield to the maternal instinct, allowing them to be fed (or the reverse) by artificial foods administered by other hands, the result being a high preventable mortality. Then we see the original bogey presenting himself through the mist, "Children are few because parents are skilled in the art of preventing conception and deliberately practise it," and thus the diminishing population question is re-introduced with considerable force of fact and argument: the births when they do occur being rendered nugatory by parental neglect, and kept down on the other hand by the selfishness of those whose higher aspiration is subordinated to the desire for a life of ease. That the population of France has remained stagnant for many years through the combined conditions referred to is a fact which cannot be denied. That the population of her neighbour Germany has increased and is increasing enormously is equally patent; the physiological basis of the one being gradually undermined by the more virile prowess of the other naturally gives point to the question raised by Mr. Sewill, Will not the stronger nation eventually absorb the weaker? And as the birth-rate in our own country is diminishing and a high infant mortality rate prevails, are we too not in danger of succumbing to the evil we deplore in our neighbours on the other side of the English Channel? Unfortunately the birth-rate of the morally and physically unfit does not diminish, and this, in my mind, constitutes the greater national danger.

I am, Sir, yours truly,
An Urban Practitioner.

"THE PASSING OF THE MEDICAL PRACTITIONER."

To the Editor of the Medical Press and Circular.

Sir,—Your excellent leader of August 9th clearly sets forth the case of the average medical practitioner from the worldly point of view—the view of the profession as a wage-earning occupation—the view unfortunately which is necessarily most forcibly and constantly presented to the bulk of its votaries, but you have not mentioned the important fact that there are too many of us. There are not enough patients to go round. When we are equally divided there is not a living to be gained by any one; if, as usually is the case, a few obtain the bulk of practice, the rest are left without the chance of earning a livelihood. I live in a first-class "residential" district within 50 miles of London. The inhabitants all told number about 25,000, and there is at least one doctor to every five hundred. Perhaps six are earning fair incomes. Of the rest, some six or eight manage to get along without too much display of the shabby over the genteel. How the rest contrive to live unless they possess private resources is a mystery. Too many men enter the profession; of these a great number have not the personal qualifications which go to the making of a practitioner who can command success with the public. Success as a practitioner, a family doctor, very largely depends upon the amount of true sympathy with human weakness and human suffering with which he is inspired, and such sympathy cannot be imitated completely by the most consummate hypocrite. Albeit it may be augmented by cultivation in those who possess its germs, it is only such a sympathetic nature that can devote his patience and highest skill to the amelioration of the petty ailments with which he is mostly called upon to deal. It is only one who has such a will who can gain the amount of esteem from his patients which places him in the position of friend and confidential adviser in every question within his province. Medicine from the worldly point of view may not be the worst of professions, but it is certainly the worst when pursued as a trade. The men who take the lowest qualifying degrees and enter practice, not only without adequate experience, but without the professional spirit, the love of their work and the sympathetic qualities which I have referred to, are doomed to failure. It is a pity men do not as a rule recognise this until too late; they linger in many false positions until middle age slips by, until it becomes impossible to extricate themselves from the position of complete failure in which too often in the end they are landed. These failures can be prevented only by putting before intending candidates a full and clear statement of the difficulties which environ the medical life; and seeing how pathetic and pitiable becomes the fate of many of our brethren who have lacked this essential preliminary knowledge, it is deeply to be regretted that the full unvarnished truth is not impressed upon every student within the earliest suitable period of his novitiate.

I am, Sir, yours truly,
AN OBSCURE PRACTITIONER.

Literature.

ALGIERS IN WINTER. (*a*)

"FROM Cloud to Sunshine" is the title of a little book from the pen of Dr. Alfred S. Gubb, who was formerly on the editorial staff of this journal, but now in resident practice in Algiers during winter, and Aix-les-Bains in the spring and summer months. The booklet is, as its sub-title suggests, a guide to "Algiers as a winter resort," and as such will be found useful to English practitioners having patients whose health necessitates hibernation in more favoured climes than home. To the information regarding the climatic advantages of Algiers and their therapeutic bearings, are added many hints and suggestions on the selection of villas, lodgings, and hotels; the engagement of attendants and the like, which should prove of inestimable value to intending visitors. These are further supplemented by instructions how to reach Algiers, the various sea and land routes, times of departure and arrival, costs of transit, &c., which will save them the trouble and anxiety of hunting up such necessary information for themselves. Formerly hotel accommodation was scanty, uncomfortable, and excessively dear, but the author tells us this is now a thing of the past, excellently managed hotels having been provided to suit all purses, and attractions studied in various ways for those who visit Algiers either for health, pleasure, or both.

Obituary.

GRIFFITH WILLIAMS ROBERTS, L.R.C.P.Ed., L.F.P.S.Gl., M.D.St. And.

We regret to announce the death on Thursday of Dr. Griffith Williams Roberts, medical officer for the borough of Denbigh. Dr. Roberts had been in ill-health for some time. The Town Council was in session at the time, and had just appointed Dr. Roberts' son as deputy medical officer, when the news was received that the father had passed away. Dr. Roberts was 64 years of age, and was appointed medical officer in 1879. He was the centre of a wide circle of friends and patients by whom he will be mourned. He was educated at Edinburgh, and took the qualifications of L.R.C.P. in 1864 and M.D. St. And. in 1882.

Medical News.

A Nothnagel Scholarship.

THE Senate of Vienna University has decided to devote £1,000 to the purpose of establishing a scholarship in memory of the late Professor Nothnagel. The prize is to be awarded to the essay which gives the best answers to medical problems proposed yearly by the Senate. In the case of no essay being considered worthy of the prize, the money is to be laid out with a view to encourage original research on diseases of the intestines.

Red Cross Society of Japan.

THE Red Cross Society of Japan is, by its creation, the last of Red Cross societies, but it is by far the first and foremost of these societies by its splendid organisation, its wealth, and its power for good. The Japanese Red Cross Society had recently 920,000 members; its funds in hand amounted before the war to £794,000; and it possessed an annual income of £231,000.

Prize Offered for a Cancer Cure.

THE Brazilian Chamber of Commerce, we learn on the authority of the *Pall Mall Gazette*, has devoted the handsome sum of £400,000 as a prize to be given to the scientist who shall discover a really enduring method for the cure of cancer. An international committee is to be formed, consisting of two members of the Medical Academy in Rio Janeiro, and of four eminent pathologists chosen from London, Paris, and Rome. These six gentlemen will act as the jury in the case of awarding the prize.

PASS LISTS.

Society of Apothecaries in London, August, 1905.

THE following candidates have passed in:—

Surgery.—H. J. Aldous (Section II.), C. W. S. Boggs (Section II.), H. A. Browning (Sections I. and II.), G. M. Seagrove (Section II.).

Medcine.—F. D. Addis, C. W. S. Boggs (Section II.), J. H. Harrison (Section II.), F. J. F. Jones (Section I.), E. B. Miles, W. G. O'Malley (Sections I. and II.), W. V. Pegler (Section II.), N. A. Stutterheim (Sections I. and II.), A. Whitby.

Forensic Medicine.—E. Moir, N. A. Stutterheim.

Midwifery.—E. Moir, A. F. Palmer, F. C. H. Powell.

The Diploma of the Society was granted to the following candidates, entitling them to practise medicine, surgery, and midwifery:—Messrs. H. J. Aldous, C. W. S. Boggs, H. A. Browning, E. B. Miles, and N. A. Stutterheim.

As a commentary on the vast amount of temperance agitation that has been carried on in Stepney during the past few years 96 deaths were reported last year as attributable to drink.

DR. H. KENWOOD, Medical Officer of Health for Stoke Newington, says in his annual report that "If the death-rate among calves were only one-half of that which prevails amongst infants, the British farmer would before very long have to entirely give up the business of rearing cattle."

(*a*) "From Cloud to Sunshine." By Alfred S. Gubb, M.D., M.R.C.S., D.P.H. London: Bailliere, Tindall and Cox. 1905.

Notices to Correspondents, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

M. O. H. (Grimsby).—It is estimated that 218,000 children in England and Wales are paupers and brought up at the cost of the ratepayers. Nearly half of all children born in the two countries die in the first year of life. Sir Francis Galton delivered at the Anthropological Institute an able lecture on "The Possible Improvement of the Human Breed under the Existing Conditions of Law and Sentiment."

PATERFAMILIAS.—At the smaller institution, the student has probably a better chance of acquiring the practical knowledge of his profession. At the hospital to which you refer, every student is required to serve as Out-patients' Dresser for a period of four months, and as In-patients' Dresser for a further period of four months; and while holding the former appointment is required to act as Clinical Clerk in the Surgical Wards under the direction of the Surgical Registrar.

DR. H. (Bangor).—(i) Efforts to influence cancer growth by immune (cytolytic) sera or to interpret the more minute cell changes accompanying different Phases of growth have not yet led to any definite conclusions. (ii) Specimens of carcinoma and sarcoma have now been obtained for the first time from native races inhabiting various tropical regions.

DENTAL SURGEON.—The first important work on the subject of dentigerous cysts was published in 1872 by Magitot, the well known Paris dentist.

DR. L. (Buxton).—In every case of death in a lunatic asylum the authorities are required to forward a report to the coroner. Upon receipt it is within the province of the latter to make any further inquiries.

M. O. H.—The paper you refer to on the evils of kissing is by Dr. Charles Féré and appeared in the *Revue de Medecine.* He includes syphilis, tuberculosis, diphtheria, exanthematous fevers and various forms of skin eruption. The injunction to friends visiting patients in consumptive hospitals not to kiss seems based on sound commonsense.

JUSTICE.—You could not do better than join the London and Counties Medical Protection Society. Last year it dealt with 13 claims for damages for alleged negligence and most of these were proved unjust. Also 33 cases of libel or slander were met successfully.

NAVAL SURGEON.—There is a handy little volume, "The Ship Surgeon's Pocket Book," 2s. 6d., published by Bailliere, Tindall & Cox which ought to meet all your requirements. It is written by Mr. W. E. Dawson, Admiralty Surgeon.

RÖNTGEN.—The Russian Institute of Experimental Medicine has announced a prize, value £100, for the best treatise on Radium in skin diseases and particularly cancer. The award will be made January 14th, 1908.

A LONDON Surgeon who recently wanted to send some cases to a medical conference to illustrate a paper on cleft palate, wrote to the railway company asking them to provide for the same. On the date appointed a furniture van came up to his door "to fetch the 30 cases." The idea of "cases" otherwise than wooden did not seem to have occurred to them.

T. WILSON.—The gentleman referred to was a manufacturing chemist, not a medical man as has been generally supposed. His doctorate was LL.D. *Honoris Causa.*

PROVINCIAL SURGEON.—The translation by Dr. Foy, which appears in another columns of our present issue of service under the Red Cross, during the war in the East will supply you with the information you seek

CATGUT.—The origin of the term is obscure, none of the various so-called explanations are satisfactory in any case. We can reply to your question definitely as to its manufacture: the ligatures used in surgical practice are made from the intestines of sheep, not from those of the domestic animal whose name it bears.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, AUGUST 23rd.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—4.15 p.m. Dr. Russell: Medical Cases.

THURSDAY, AUGUST 24th.

POST-GRADUATE COLLEGE West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. Davis: Tonsillitis and its Treatment.

FRIDAY, AUGUST 25th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Paget: Surgical Cases.

Vacancies.

Noble's Isle of Man Hospital and Dispensary, Douglas, Isle of Man.—Resident House Surgeon. Salary £90 per annum, with board and washing. Applications to Richd. D. Gelling, Honorary Secretary, St. George's Chambers, Athol Street, Douglas, Isle of Man.

Essex and Colchester General Hospital.—House Surgeon, Salary £100 per annum, with board, washing and residence in the Hospital. Applications to Alfred G. Buck, Secretary, The Hospital, Colchester.

City of Liverpool Infectious Diseases Hospitals.—Assistant Resident Medical Officer. Salary £120 per annum, together with washing, and lodging at the Hospital. Applications to the Town Clerk, Municipal Offices, Liverpool.

The Municipality of the Town of Singapore, Straits Settlements.—Assistant Municipal Health Officer. Salary £400 per annum. Applications to C. C. Lindsay, Esq., M.Inst.C.E., 180 Hope Street, Glasgow.

Kent County Ophthalmic Hospital, Maidstone.—House Surgeon. Salary £100 per annum, with board, to reside in the Hospital. Applications to the Secretary.

East Riding Lunatic Asylum, Beverley.—Second Assistant Medical Officer. Salary £150 per annum, with board, apartments, and washing. Applications to C. W. Hobson, Clerk to the Visiting Committee.

Berkshire Asylum, Wallingford.—Second Assistant Medical Officer. Salary £140 per annum, with board, furnished apartments, attendance, &c. Applications to the Medical Superintendent.

Lanark District Asylum.—Third Assistant Medical Officer. Salary £120 per annum, with fees, &c. Applications to Neil T. Kerr, Medical Superintendent. (See Advt.)

Appointments.

BARCLAY, WILLIAM BOWIE, L.R.C.P., L.R.C.S., L.M.Edin., D.P.H. Vict., Medical Officer of Health of Weymouth.

BOND, FRANK FOURACRE, L.R.C.P.Lond., M.R.C.S.Eng., Medical Officer to the Trowbridge (Wilts) and District Isolation Hospital.

CUNLIFFE, THOMAS VARLEY, M.D., B.S.Lond., M.R.C.S., L.R.C.P. Lond., Assistant Surgeon to the Oldham Infirmary.

KELLEHER, T. A., M.B., B.S.R.U.I., Certifying Surgeon under the Factory and Workshop Act for the Waterford District of the county of Waterford.

KELLY, W., M.B., C.M.Aberd., Clinical Assistant to the Chelsea Hospital for Women.

MASON, A., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Deal District of the county of Kent.

REES, W. H., M.B., F.R.C.S., Registrar to the Bolingbroke Hospital, Wandsworth Common, S.W.

Births.

FISCHER.—On August 17th, at Edinburgh, the wife of Dr. Fischer, Cairo, of a daughter.

FITZGERALD.—On August 13th, at Eglinton Asylum, Dr. Lucia FitzGerald, the wife of Dr. John J. FitzGerald, of a daughter.

KENNEDY.—On August 15th, at 39 Harrington Street, Dublin, the wife of Surgeon Kennedy of a daughter.

PARKINSON.—On August 15th, at 57 Wimpole Street, London, wife of J. Porter Parkinson, M.D., M.R.C.P., of a daughter.

RUSSELL.—On August 17th, at Osman House, Fortis Green, London, the wife of J. Dill Russell, M.B., B.S.Lond., F.R.C.S.Eng., of a daughter.

WILSON.—On August 16th, at Marden Ash, Ongar, the wife of Geoffrey R. Wilson, M.A., M.B., B.C.Cantab., of a daughter (still-born).

Marriages.

CALEY—GREEN.—On August 17th, at All Saints' Church, East Budleigh, Devon, Henry Albert Caley, M.D., F.R.C.P., of 24 Upper Berkeley Street, London, to Dorothy, second daughter of Rev. W. F. Green, M.A., Vicar of East Budleigh.

ZILWA—SACHS.—On August 12th, at Park Chapel, Camden Town, London, Lucian Arnold Emmanuel de Zilwa, M.B., B.Sc.Lond., of Ceylon, to Charlotte Eleanor (Lena) Sachs, elder daughter of Mrs. Sachs, and the late John Sachs, of Chancery Lane and Camden Town, and granddaughter of the late Titus Danks, of Dean Street, Soho.

Deaths.

HESSION.—On August 13th, at Norwich, Brigade-Surgeon Thomas Oliver Hession, late Army Medical Department, aged 70.

KILROY.—On August 13th, at Paramé, France, Philip Le Feuvre Kilroy, Lt.-Col. R.A.M.C., of Eastfield, Ryde, I.W., aged 61 years.

PRACTICE.—Wanted to Purchase a small practice, near Dublin. Sea-side preferred. Reply to B. B., care of MEDICAL PRESS AND CIRCULAR, 16 Lincoln Place, Dublin.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, AUGUST 30, 1905. No. 9.

Original Communications.

OCULAR THERAPEUTICS. (a)

By SYDNEY STEPHENSON, M.B., F.R.C.S.E.

(*Continued from Page* 185.)

LECTURE IV.

6.—GENERAL REMEDIES.

General Anæsthesia.—Since the introduction of cocaine by Koller in 1884 there has been a growing disinclination among ophthalmic surgeons to operate under general narcosis if it can be avoided. This tendency is reflected in a recent paper by Dr. Otto Meyer, of Breslau, upon removal of the eyeball under combined local anæsthesia, which appeared in the *Klinische Monatsblatter f. Augenheilkunde* for February last. He had undertaken eighty enucleations of the eyeball under the local anæsthesia produced by instillations of cocaine and the injection deeply into the orbit of Schleich's No. 2 solution. The reaction, however, has assuredly gone too far when we find so eminent an author as Professor Haab, of Zurich, practically advocating the abandonment of general anæsthesia in operative eye work. In his recently published *Augen-Operationslehre* (a work that should be in the hands of every ophthalmic student) Professor Haab takes what strikes me as an altogether exaggerated view of the dangers attendant on almost every form of general narcosis. Everyone will of course admit that if an operation on the eye can be done painlessly under local anæsthesia so much the better, on account of the preparation needed, the time consumed, the risks incurred, and the possibility of vomiting. Professor Haab, however, goes much farther, and advises against the induction of general anæsthesia on account of its danger to life. If his views were accepted generally, the present generation would be denied one of the greatest blessings bestowed upon mankind, namely, the possibility of performing the most severe operations without inflicting the least pain upon the patient. It is obvious that a certain percentage mortality is bound to attend the administration of any general anæsthetic, be it chloroform, ether, ethyl chloride, nitrous oxide, or any other. The relatively greater risk attending the first-named agent has rendered its administration by trained anæsthetists rarer than was once the case. The common practice now is to give gas or ethyl chloride at the start, and then ether or chloroform. Accidents will become less numerous as training in the giving of anæsthetics becomes more general. After all, the risk in skilled hands of giving ethyl chloride or gas and ether is a small one, and I seriously question whether the infinitesimal risks thereby incurred justify us in withholding from our patients the boons of general anæsthesia.

In point of fact, a general anæsthetic is almost indispensable in certain operations upon the eye—as, for example, in acute glaucoma and some other conditions where the parts are so deeply engorged with blood as to be incapable of absorbing the amount of cocaine or holocaine necessary to produce local anæsthesia. In children, again, there are few operations that can be done with comfort to the surgeon or with safety to the patient under cocaine, for in them it is not pain so much as fright that has to be contended against. Until recently chloroform was the favourite anæsthetic, probably because it was generally available and called for no complicated apparatus, like ether, liable, perhaps at a critical moment, to get into the operator's way. Doubtless, chloroform or ether will remain the anæsthetic for such operations as require a period of prolonged unconsciousness. For brief periods of anæsthesia, however, such as suffice for most operations upon the eye, ethyl chloride is the best agent. It is speedy, relatively safe, easy to give, and produces an anæsthesia free from muscular twitchings, so embarrassing to the eye surgeon. Vomiting, in my experience, is generally due to an overdose.

Much of my personal experience, which now extends to upwards of three hundred administrations, has been gained with "kelene," merely an extraordinarily pure form of ethyl chloride. But Duncan and Flockhart's "chloryl anæsthetic" and Hedley's "ethyl chloride" also represent pure products at a cheaper rate. With regard to the apparatus, there are now several good inhalers available, among which may be mentioned the modified Ormsby ether inhaler made by Messrs. Krohne and Sesemann, and the "Simplex" inhaler of Messrs. Duncan and Flockhart. The point to be aimed at in a good apparatus is the complete or almost complete exclusion of atmospheric air. The mask is fitted to the patient's face, 2 c.c. to 6 c.c. of ethyl chloride sprayed into the face-piece, and the apparatus held over the mouth and nose until general anæsthesia is produced, a thing that, as a rule, does not take more than thirty seconds. The unconsciousness from a single dose lasts from one to three minutes—that is, long enough to perform many of the operations of ophthalmic surgery. If necessary, a longer period of anæsthesia may be obtained by giving a second dose of ethyl chloride or by continuing the inhalation with ether or chloroform. Insensibility is shown by snoring respirations, insensitive corneæ, flaccid limbs, and in the case of children by absence of muscular response to a sharp nip in some tender portion of the body. With ethyl chloride a patient may be anæsthetised, operated on, and recover within five minutes, an economy of time that will be appreciated by all who have to work in a crowded and busy out-patient department.

References to Ethyl Chloride in Eye Work—

1. Fromaget.—*Annales d'Oculistique*, 1901, p. 196.
2. Stephenson and Chaldecott.—*Ophthalmoscope*, 1904, p. 129.
3. Valude.—*Recueil des Travaux Xe Congres international d'Ophtalmologie, Lucerne*, September, 1904.
4. Hird, B.—*Ophthalmoscope*, March, 1905, p. 122.

ANIMAL ORGANOTHERAPY

Apart from suprarenal extract, which has already been considered, two animal extracts have been employed in eye work—"didymine" and "optocine." The treatment of exophthalmic goitre by Dr. Moebius's "antithyroidin" (Merck)—i.e., the blood-serum of rams from which the thyroid gland has been removed, with 0·5 per cent. of added carbolic acid—need scarcely be described in this place, although it is clearly of interest to ophthalmic as well as to general surgeons.

(a) Lectures delivered June, 1905, at the Polyclinic London.

Didymine, or testicular substance, has been used internally in locomotor ataxy. Dr. Lloyd Roberts has recently reported several cases of exophthalmic goitre relieved by its administration, one to five four 5-grain tabloids (Burroughs Wellcome and Co.) being administered several times a day. Testicular extract has been put to a curious and out-of-the-way use by Dr. L. Dor (*Recueil des Travaux Xe Congres international d'Ophtalmologie*, September, 1904), who gave the product to five children in whom rapid growth was associated with symptoms of asthenopia. Growth was retarded, and incidentally asthenopia improved.

Optocine is the name given to a potent extract from the retinæ of freshly slaughtered animals. It is administered in various forms of retinal exhaustion—as, for example, in tobacco amblyopia, in retinitis pigmentosa and in myopic choroiditis. The dose is one drachm two or three times a day. Mr. Robert W. Doyne was the first to bring this novel product under the notice of the medical profession, and those interested in the subject are advised to consult his original communications in the *British Medical Journal* of July 25th and September 26th, 1903. In this place I will merely say that it does appear to expedite recovery in tobacco amblyopia, although it is most difficult in that as in other diseases that tend to self-cure to estimate "optocine" at its true value. I have, however, more than once seen sight improve in such cases even when the patient continued to smoke immoderately. As a matter of some slight historical interest it should be pointed out that extracts from various parts of the eye have been employed by Dor in 1897, by Lagrange in 1898, and by Darier in 1900.

SERUMTHERAPY.

Antitoxic sera have been employed in ophthalmology in the treatment of four conditions, viz.:—1. Diphtheria of the conjunctiva; 2. Hypopyon-ulcer of the cornea; 3. Ocular tuberculosis; and 4. Streptococcal and staphylococcal invasions.

1. *Diphtheria of the Conjunctiva.*—Diphtheria of the conjunctiva is tolerably common among young children of the lower classes in London. According to my personal experience, it forms 1·26 per cent. of the eye cases presented for treatment in the ophthalmic department of a children's hospital. It usually occurs in a mild form, much resembling acute muco-purulent ophthalmia, and is doubtless often mistaken for the latter disease. There is, however, membrane upon the conjunctiva, a point that should suffice to distinguish the two affections. Even fatal cases are not unknown in this country. Mr. Percy Flemming has described such a case in an infant of four months; Dr. Bullar had a fatal case in a baby of ten days; and I have myself had two fatal cases in children, aged respectively 11 and 16 months. The treatment, which should be commenced as early as possible, is by the injection of diphtheria antitoxin, the dose of which will depend not upon the age of the child but upon the severity of the disease. Indeed, the serum appears to be productive of nothing but good, no matter in what dose it is injected. "Mixed injections," as they are called, are very common. Thus, among forty-two cases of diphtheria of the conjunctiva published by me a year or so ago, they occurred in no less than 86·04 per cent. Hence, in addition to antitoxin, local antiseptics should be applied to the conjunctiva. Many remedies may be used for this purpose, but, upon the whole, I have found a 15 per cent. solution of argyrol to succeed as well as anything else I have tried.

2. *Hypopyon-Ulcer of the Cornea.*—There is no more fatal disease of the eye than the one usually termed in England "hypopyon-ulcer," and elsewhere "ulcus serpens corneæ." An elderly person, usually of the labouring classes, with unsound lacrymal passages, receives, in the course of his work, some trifling injury to his cornea. The little wound or abrasion, instead of healing promptly as it would do in a healthy subject, becomes infected with pneumococci from the diseased lacrymal passages, pus appears in the anterior chamber, the ulcer spreads, and in the absence of prompt and well-directed treatment, the eye is only too likely to be lost. The usual treatment of the condition includes slitting the canaliculus, in order to give exit to the infectious secretions of the lacrymal sac, and, above all, the application of the galvano-cautery to the aggressive edge of the corneal ulceration. Saemisch's method—that is, opening the anterior chamber by means of an incision including the entire thickness of the ulcer—is practised by many operators, despite the fact that it is often followed by an adhesion between cornea and iris, which later may have disastrous consequences.

Römer, of Wurzburg, has experimented in this condition with a polyvalent serum of high potency, prepared by Merck, of Darmstadt (*von Graefe's Archiv f. Ophthalmologie*, Vol. 54, No. I., and *Bericht der Ophthalmologischen Gesellschaft, Heidelberg*, 1902 and 1903). The hypopyon-keratitis was produced in rabbits and monkeys by inoculating the cornea with pneumococci, and Römer's series also included clinical cases as met with in man. Cases treated early almost invariably healed well, whilst almost 80 per cent. of successes were obtained even when the condition was advanced. In 95 per cent. of cases of hypopyon-keratitis the pneumococcus is present. In the earlier experiments the serum was injected beneath the skin and the conjunctiva and also applied directly to the corneal ulcer, but, later, Römer discarded the subconjunctival injections. Several Continental observers have now experimented with Römer's pneumococcic serum, and, as usual, there is no unanimity of opinion with regard to its true clinical value. It is, however, agreed that ulcus serpens produced by experimental inoculation does yield in many instances to the serum. Paul, Augstein, and Zur Nedden, who among them treated 32 ordinary cases of hypopyon-keratitis, obtained a cure with the serum in six only. In the remaining cases, amounting to 81 per cent. of the total number, the cautery had to be applied or the Saemisch section performed before the destructive corneal process could be checked. Paul, one of the most recent writers on the subject, goes so far as to say that the pneumococcic serum should be adopted in exceptional cases only, and that commonly preference should be given to surgical measures (*Klin. Monatsblatter f. Augenheilkunde*, January, 1905). Another writer, Oliveres (*La Clinique Ophthalmologique*, June 25th, 1905), has treated three cases of ulcus serpens with Römer's serum, but in every instance had to resort to other measures, especially the subconjunctival injection of mercury cyanide, before he could obtain cure. Finally, from certain observations made by Zeller, *Med. Corresp.—Blatt des Wurtt. artzlichen Landesvereins*, September 3rd, 1904), it appears that the use of serum is not always free from danger. For example, in a case mentioned by him the injections are stated to have been followed by myocarditis.

3. *Ocular Tuberculosis.*—The tuberculous diseases of the eye are numerous and important, although not perhaps altogether common. They include tuberculosis of the conjunctiva, iris, choroid, and lacrymal sac. The superficial manifestations can be attacked with the knife, sharp spoon, cautery, or X-rays, but until recently our means of dealing with the deeper lesions were limited indeed. In fact, the management of such affections was on the lines now generally adopted in treating phthisis pulmonalis—that is to say, by living in open air and bright sunshine, by well-cooked and generous diet, and by careful attention to the state of the skin and other emunctories. Now, thanks to serumtherapy, we appear to be reaching

more tangible and solid ground. "Tuberculin T.R." has been employed by von Hippel (*von Graefe's Archiv f. Ophthalmologie*, August 9th, 1904), in the treatment of fourteen cases of ocular tuberculosis, affecting cornea and uveal tract in thirteen cases, conjunctiva in three cases, and sclera in one case. The injections are gradually increased from 1—500 milligramme up to, but never beyond, 1 milligramme of the product, and are made every other day. The temperature is taken at two-hourly intervals, and should it exceed 100·5° F., no increase in the dose of the tuberculin must be made. In serious cases quite six months' treatment is called for. Von Hippel has never met with any bad effect as regards the general health. But a case recently published by Contino (*La Clinica Oculistica*, November-December, 1904), shows that there may be a reverse to the medal. A child of 10 years suffering from a tuberculous ulceration of the conjunctiva was treated by serum, antitoxic and another, with the consequence that the lesion healed in about a month. Five weeks later, however, the child became very ill, and died comatose in a few days from tuberculous meningitis.

I am not disposed to attach undue importance to Contino's observation, because I have seen something of the same kind happen where serum had not been injected. A child, æt. 17 months, presented a tuberculous ulceration towards the centre of the free edge of one lower lid. Twenty-one days later, she was found to have double optic papillitis and tubercle of the choroid. She died twenty-five days after the first examination from milary tuberculosis (*British Medical Journal*, May 3rd, 1902.)

4. *Pyogenic Invasions of the Eye.*—In certain streptococcus invasions of the eye, as occurs in infected wounds, operative or accidental, antistreptococcus serum has been tried. Claiborne and Coburn, however, as the results of their experiments upon rabbits, conclude that it exerts no favourable influence upon the course of these invasions (*Medical News*, August 6th, 1904). The same serum has also been successfully employed by Darier in a case of purulent ophthalmia in a baby associated not with the gonococcus but with streptococci.

7.—GENERAL CONSTITUTIONAL REMEDIES.

Almost every constitutional affection has its correlated eye disease, and he would be indeed a benighted specialist who employed local treatment to the neglect of general remedies. From a purely practical point of view, two affections of general nature stand prominently forward as causes of disease of the eye, viz., syphilis and rheumatism.

1. *Syphilis.*—Syphilis, acquired and inherited, is the commonest constitutional cause of ocular disease. The acquired disorder is responsible for iritis, cyclitis, choroiditis, retinitis, and for some cases of interstitial keratitis, to name a few alone among the so-called "specific" affections of the eye. The inherited disorder is the common and usual course of interstitial keratitis, and also produces choroido-retinitis, and occasionally oculo-motor paralysis.

In the treatment of the several conditions named mercury and potassium iodide are still our sheet-anchors. But during the last few years new and efficacious ways of administering mercury have been widely employed, more especially upon the Continent. These comprise (*a*) subcutaneous or, rather, intramuscular injection, and (*b*) intravenous injection, in each case of soluble mercurial salts. The employment of insoluble compounds, as calomel, appears to be attended with considerable danger, and personally I have had no experience of the method.

(*a*) Intramuscular injections have yielded me some brilliant results in cases, as interstitial keratitis and choroiditis, that refused to yield to the ordinary modes of administration—that is, by the mouth or by inunction. I once employed a solution of corrosive sublimate (1 grain of the salt to 1 drachm of sterilised water: dose, 10 minims twice or thrice a week), which was deeply injected into the gluteal muscles, after the skin of the buttocks had been carefully cleansed with soft soap, hot water, ether, and a solution of corrosive sublimate in carbolic lotion. There were, however, certain inconveniences. It was sometimes inadvisable to expose the buttocks, especially in the case of an adult member of the opposite sex. Although I never saw suppuration follow injection, yet the formation of a hard and tender lump on a sensitive part of the body, persisting for several days, was not a thing to be particularly desired. Then, the frequent repetition of injections rendered the part hard and indurated. Moreover, gummata may very occasionally appear at the point of injection of the mercurial fluid, either speedily or not until several months or even years have elapsed. Thus, Juliusberg (*Munch. Med. Woch.*, April 14th, 1903), reported three cases in which such gummata appeared nine months, eighteen months, and several years respectively after the injection. A patient of my own, where injections had been made into the biceps of the upper arm, developed a gumma locally in the course of two or three weeks. The points named have led me to employ not corrosive sublimate but a 1 per cent. solution of mercury cyanide. The results were as good as with the other salt, and no painful lump is ever produced at the site of injection. The exposure of the patient, however, is still a disadvantage. I have no experience of sublamin, a 3 per cent. to 4 per cent. solution of which has been recommended for intra-muscular injection (*Therapist*, January 15th, 1904).

(*b*) The method I now prefer is the intravenous injection of a solution of mercury cyanide in physiological salt solution. The formula is:—Cyanide, 1; sodium chloride, 0·75; boiled distilled water, 100. Dose, 20 to 40 minims in urgent cases daily, and in others twice or thrice a week. The biniodide salt may also be employed according to the formula:—Mercury biniodide, 1; sodium iodide, 2; boiled distilled water, 100. Dose, 20 to 60 drops (1 c.c. to 3c.c.).

The injection may, of course, be made into any accessible vein that is large and prominent enough, but usually the veins at the end of the elbow—the median cephalic and the median basilic—are the most convenient. Occasionally, the veins of the forearm or the cephalic or the basilic of the upper arm are suitable vessels for our purpose.

The parts are exposed, the vein selected, and a fillet is tied rather tightly around the middle of the upper arm. The skin over the arm is next carefully cleansed and sterilised. The vein is then steadied with the operator's thumb, and the needle pushed obliquely through its anterior wall. Penetration will be at once obvious either by blood falling into the syringe (which should, of course, have a glass barrel) or by rising on slightly withdrawing the piston of the instrument. No injection should ever be made until one of these two things has happened, as otherwise the fluid may be forced into the perivenous connective tissue, where it may cause considerable irritation. The contents of the syringe are then slowly pressed into the vein, the fillet having first been removed. Finally, the needle is withdrawn, and the tiny puncture sealed with collodion, or, if it does not leak, left without dressing of any kind. The injection is painless, provided the needle is passed into the vein without bungling. Timid patients may become faint when the first injection is made. Sometimes a curious and indescribable taste in the mouth is complained of a few moments after the operation is completed.

It is important to bear in mind that signs of mercurial intolerance tell mainly upon the intestinal canal and not upon the mouth in these methods of administering the drug. They include colic and diarrhœa. For some few years I have been familiar with another sign of the mercurial action, which, so far as I know, has not yet been described. It consists in the formation of a red crescent at the free border of the nails, and its dimensions, in my experience, afford an excellent guide to the action of the mercury. It is better seen on the finger nails, since they are thinner than the nails of the toes, and for obvious reasons it is generally much better marked among the upper than the lower classes.

Before leaving the subject I should like to state clearly that I am in no sense an advocate of injections, except in particular and selected cases. There are many specific affections of the eye that can be treated efficiently by the internal administration of mercury with chalk or other familiar preparation of mercury. It is in diseases, the existence of which threatens to destroy sight or which refuse to yield to ordinary methods that we should, I think, inject the remedy. The disadvantages of intravenous injection are that it consumes time, may alarm timid patients, and that it is not always easy, and indeed sometimes impossible, especially in women and children, to find a vein suitable for our purpose. On the other hand, the process is simple, painless, free from danger, speedy in its effects, and presents the advantage that it is carried out by the medical man himself. I have satified myself that it is efficacious in many cases of choroiditis, specific and otherwise, upon which the ordinary preparations of mercury failed to procure any effect.

2. *Rheumatism.*—The precise relationship of rheumatism to many diseases of the eye is still unsettled. The word "rheumatic" is a legacy from old times, and is often even nowadays employed to cloak our ignorance of the essential nature of some ocular disorders. At the same time, certain diseases of the eye are undoubtedly of rheumatic origin. Of these the best-known is perhaps irido-cyclitis. A few years ago a theory was propounded by Dr. David Walsh that certain skin affections could be accounted for by excretion from the body of various irritants, such as drugs, micro-organisms, and toxins. It occurred to me (*Lancet*, February 29th, 1896) that the explanation, if correct, should apply to organs other than the skin, engaged in the work of excretion. Now almost all the general ailments capable of causing an inflammation of the iris are associated with, if not actually caused by, micro-organisms. That fact will be disputed by none as regards syphilis, gonorrhœa, tubercle, leprosy, influenza, and relapsing fever. If the bacterial origin of rheumatism be admitted, then a common cause of iritis will fall into line with the rarer causes enumerated above, for it must be remembered that the ciliary body secretes the aqueous humour (E. T. Collins). The position might be stated in terms of a syllogism, as follows:—Most inflammations of the iris and ciliary body are dependent upon a constitutional ailment; a majority of these ailments are of bacterial nature; therefore, most forms of irido-cyclitis result from the action of micro-organisms. It was suggested as possible that the immediate cause of these inflammations might be sought in the vicarious glandular excretion of microbes or their products circulating in the blood or other nutrient fluids of the body. Since then Drs. Poynton and Paine have isolated from the lesions of acute rheumatism a minute diplococcus, now very generally accepted as the specific pathogenic agent. Not the least interesting result obtained by those workers has been the experimental production in rabbits of iritis by the injection of a pure culture of their "diplococcus rheumaticus" into the auricular vein of rabbits. The animals died of heart disease, and the causative organisms were found in the cloudy fluid of the anterior chamber of the affected eyes. A culture from that fluid, when injected into another rabbit, gave rise to chronic arthritis (*Ophthalmoscope*, October, 1903). The rheumatic origin of certain cases of irido-cyclitis has therefore been established both theoretically and experimentally. In my own mind, I entertain no doubt that conjunctivitis is rarely and episcleritis commonly due to chronic articular rheumatism.

As to palsy of the ocular muscles and its "rheumatic" origin I am somewhat sceptical. Such patients, when watched long enough, are not infrequently found to develop serious nervous lesions, more especially insular sclerosis or tabes dorsalis. I may quote briefly the main facts of two such cases, of which the first eventually proved to be an instance of insular sclerosis, and the second was one of tabes dorsalis, presenting some resemblance to a so-called "rheumatic" paresis. *Case No.* 1.—Miss Y———, æt. 24, who gave a history of chronic articular rheumatism, consulted me in February, 1890, on account of a palsy of the left external rectus muscle, of some weeks' duration. The paralysis was assigned to rheumatism, a diagnosis apparently confirmed by the fact that recovery took place in about three weeks under ordinary anti-rheumatic treatment. In the beginning of 1900—that is, ten years later—Miss Y———again came to me, on this occasion with paralysis of the right external rectus muscle. She also presented nystagmoid movements of the eyes, trembling of the legs, exaggerated knee-jerks, ankle clonus, and paræsthetic areas about the lower extremities. There was a history of occasional incontinence of urine, and of unsteadiness in the street. The diagnosis of insular sclerosis then seemed obvious, and it was reasonable to look upon the first attack of ocular palsy ten years before as a premonitory sign of that disease. *Case No.* 2.—Mr. W———, æt. 33, seen May 26th, 1905, complained that he had seen double for two days, and gave a history of a similar attack ten years ago, which lasted for about five weeks. Rheumatic fever at 7 years and "rheumatism and pleurisy" at 13 years of age. Patient subject in damp weather to pains in the arms and legs, and for three months had suffered from pains over the right eye and at the back of the neck. Upon examination, paresis of the right external rectus. Both optic discs, especially the right one, greyish; retinal vessels of good size. R.V. = 6/60 and No. 18 Jaeger; L.V. = 6/36—I.25, D. Sph. = 6/12. Knee-jerks absent, even on re-inforcement. No pupillary signs. This patient furnished an excellent example of tabetic paresis (and optic atrophy) resembling a so-called "rheumatic" paresis, and easily capable of being confounded with the latter.

In "rheumatic" affections of the eye, in addition to local measures, one generally administers liberal doses of sodium salicylate, a drug that often acts admirably in relieving pain and subduing inflammation. Foucher (*L'Ophtalmologie provinciale*, August, 1904) has gone a step further, and treated three cases of rheumatic iritis by injecting beneath the conjunctiva a few drops of a 1 per cent. solution of sodium salicylate, and in another case he obtained relief to pain by injecting the same solution beneath the skin of the temple. For some little time I have employed in these rheumatic affections of the eye another salicyl compound, the name of which will certainly be familiar to all in this room, namely, aspirin. It is non-depressant, rapid in action, and seldom causes unpleasant symptoms, such as nausea and tinnitus. Administered in doses of 15 to 30 grains three or four times a day, its action upon rheumatic iritis is often surprising, while its power in relieving pain is sometimes as grateful to the patient as it is unexpected by the practitioner. It is a remedy in rheumatic diseases of the eye that I would commend to your very earnest attention. Galezowski (*Recueil d'Ophtalmologie*, 1903, p. 179) and Frank (*American Journal of Ophthalmology*, June 1904), have testified to the efficiency of aspirin in rheumatic iritis. I would add, in concluding, that the pain of severe rheumatic iritis was relieved by Frank (*loco citato*) by painting the affected parts with diluted mesotan, the methoxy-methylester of salicylic acid. The remedy should be mixed with an equal part of olive or cotton seed oil, and be painted on the affected parts, the skin having first been carefully freed from moisture.

Conclusion.

The limited time at my disposal has allowed me to touch only the fringe of an interesting but somewhat extensive subject. Several new agents and methods, of which some give every promise of being of practical importance in the treatment of eye disease, have either been passed over altogether or else merely glanced at. Among these may be mentioned pressure-massage, intra-ocular disinfection by means of iodoform, and the treatment of infected wounds of the eye by intensive doses of mercury. What has been said, however, will, I hope, convince you that ophthalmology has not lagged behind the other branches of medicine and surgery as regards advances in the twin sisters of pharmacology and therapeutics. The results of that activity have made themselves felt in ophthalmic work by the introduction of new and valuable remedies, by accuracy of dosage, by precision of physiological action, and last, but not least, by convenience of application and of storage. It can be claimed, indeed, that the medicinal treatment of diseases of the eye is now, thanks to the labours of modern chemists and pharmacologists, fast approaching the position of an exact science.

A SCHEME FOR PROVIDING A

RESERVE OF MEDICAL OFFICERS FOR THE R.A.M.C. (*a*)

By LIEUT.-COL. VALENTINE MATTHEWS, R.A.M.C. (VOL.).

THE officers of the Royal Army Medical Corps being maintained at a strength but little above the peace requirements of the army, it is necessary to make provision for expansion during times of war. In the following notes I propose to outline a scheme for this purpose, so as to secure a reserve of officers which may be readily available in case of necessity. No doubt a certain proportion of highly distinguished medical men, as in the Boer War, would come forward and be available for special professional work, and a certain number of practitioners, whether Volunteers or otherwise, would be able to leave their practices and offer their services. Neither of these two classes would, in my opinion, be numerically large, and neither class would have any military knowledge or organisation. That part of the profession which had not settled down to practice or permanent engagements is the part from which most is to be expected. This consists of what I will call the *locum tenens* class, and of those men who have but recently qualified. Of these two, I believe the latter would be preferable, The main point is, of course, that the conditions of service shall be sufficiently attractive, and shall not unduly interfere with the future career of a newly-qualified young man who has to make his way in the world by his civil occupation. I do not think that the term of obligation should exceed one year at a time, but that, if called out during that year for actual service, the reservist medical officer should be liable for service for one year from the time he is called out. In my opinion, any longer period would impose upon the young medical men disabilities in civil life which would interfere with their future.

Practitioners would be reluctant partners or assistants with a view to partnership if they knew that their prospective partners or assistants were liable for military service; while young medical men starting on their own account would not care to risk the chance of having to throw up what they hope to be the foundation of their livelihood. Most newly-qualified men do not settle down into practice or enter into other than temporary engagements during the first year after qualifying, and practically no damage would be done to their future by entering into an obligation to serve if necessary during this period. I think that men should be given the chance of re-engaging for a second or a third year, and possibly a good many would re-engage, but I do not think it would be a good policy to engage men for more than one year at a time. A certain amount of time would have to be spent in some military medical establishment—say, about four weeks in the first year and a fortnight in subsequent years of re-engagement.

I think that during the whole period of his obligation he should hold military rank, and wear uniform when on duty. From what I have been able to gather, the definite position given by military rank places a man on a better footing than that of a civil practitioner; indeed, I know of one instance of a civil practitioner engaged to do duty at a military hospital who applied for a commission in the R.A.M.C. Volunteers simply to get military rank. With military rank and the possession of uniform also, more men would probably be induced to re-engage for a second or third year, and also, probably, many would afterwards join the R.A.M.C. Militia or Volunteers, as then one of the obstacles to a young medical man—viz., the expense of outfit—would be partly removed. I would also suggest that men so engaging should be allowed the option, as far as possible, of service abroad or at home. I think that to most young men the idea of service abroad would be the more attractive.

By what means are young medical men to be induced to take upon themselves the obligation of service if called upon? The possession of rank and the choice of serving abroad or at home would, I think, be of attraction, but there remains the question of pecuniary recompense. Men who are dependent upon their profession will not undertake obligations which will materially interfere with their livelihood, unless it is made worth their while, and, of course, the amount offered will make all the difference both in the quantity and the quality of the applicants. What one wishes to aim at is to offer sufficient to attract men of the right kind without undue extravagance in the expenditure of public money.

The pay of a private of the R.A.M.C. is about 1s. 2d. a day, and the pay of a lieutenant of the R.A.M.C. is 14s. a day—that is to say, about twelve times as much. It seems only reasonable to assume that the value of the reservist medical officer may be calculated on a similar scale, and that his pay should be in a similar proportion to the pay of the reservist private—6d. a day. This would give the reservist medical officer 6s. per diem, or £109 10s. per annum, and it is only fair to assume that the country would be justified in spending this amount to secure his services.

I do not think, however, that it would be necessary to expend this in pay. I believe that if the reservist officer got £25 a year clear for himself, a sufficient number of men would undertake the obligation of service. He should, of course, receive the pay and allowance of a lieutenant during the period of training or of actual service, and should receive a grant in addition to provide

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(*a*) Abstract of Paper read at the Royal Institute of Public Health, London Congress, 1905.

uniform. This amount must depend on the amount of uniform required. If full uniform is required it would cost from £50 to £70, but I should think that an undress uniform and mess dress ought to be sufficient, and a grant of about £15 would cover this. This grant would, of course, not be required in the second or any subsequent years.

The average number of newly-registered medical men added to the "Medical Register" in England, Scotland, and Ireland during the past five years is 1,268, and if all information on the subject of this Reserve of Medical Officers were made widely known through the various medical schools throughout the country, and if in addition a special circular were sent to each man on registration (for which purpose the General Medical Council and the various examining bodies might be asked to co-operate), the services of a good proportion of these should be obtained. In my opinion about one-third of these men should be available annually—say, in round numbers, 400. Of these, probably about 100 would re-engage for a second year, and say about 50 for a third year. They would all be young men fresh from their medical schools, receptive, keen, and able to carry on the whole of the work of a military hospital under the supervision of a small number of R.A.M.C. officers for the administrative and disciplinary work.

Preference should be given to those who have served in the Royal Army Medical Corps (Volunteers) in any rank, which service should also count towards seniority. This should be made widely known to students, and would have the double effect of strengthening the ranks of the Volunteers and of offering to the R.A.M.C. officers for the reserve who are already conversant, to some extent at least, with the duties for which they are asked to serve.

Each officer on the above basis would cost in his first year £40, plus his pay for the period of training, which I put at £20 for one month. If he served for a second year, and had a fortnight's training, he would cost £25 plus £10, and the same in subsequent years.

The cost of this would be in the first year—say 400 men—gratuity, £25; pay during training, £20; outfit allowance, £15 to £60.

First year	.. ..	£60 × 400 = £24,000
Second year	.. ..	£35 × 100 = £3,500
Third year	.. ..	£35 × 50 = £1,750
		£29,250

So that in three years there would be 550 reserve officers at a cost of £29,250, or a fraction over £53 a head—not a large sum to have the right to call upon the immediate services of a highly trained professional man.

I believe that the scheme I have sketched out would be popular, and as the cost of each officer is less than six times that of the reservist soldier, I do not think it can be called excessive. To recapitulate, the main points are:—

1. The limit of obligation for a year at a time, with liability for a year's service if actually called out for service, from the time of being called upon.
2. The choice of serving abroad or at home—as far as the exigencies of the Service permit.
3. Military rank and status.
4. A clear £25 a year after payment of all expenses.

I have ventured to put forward these notes of a scheme with the hope that others may be induced to consider this subject, and that there may be some points in this which may be of possible assistance to the authorities who are endeavouring to provide an efficient and reliable reserve.

GANGRENOUS TRAUMATIC HERNIA. (a)

By WILLIAM TAYLOR, M.B., Dub. Univ. F.R.C.S.I.,

Member of the Council, Royal College of Surgeons, Ireland; Surgeon to the Meath Hospital and Co. Dublin Infirmary, and Surgeon to Cork Street Hospital, Dublin.

The subject of my communication to-night is again, as have been most of my previous communications to this club, that of an old theme, but the case I take to illustrate it has, I think, at least one feature alike interesting and uncommon to redeem it.

The case is that of a young gentleman, æt. 27 or 28, who, on the evening of July 24th, received a kick from one of his horses on the left groin. Dr. Nolans, of Gorey, Co. Wexford, was sent for some hours later, and on arrival found, on examination, the scrotum and penis greatly swollen and ecchymosed, while the left inguinal region—the site of the injury—was also swollen and discoloured, the skin being slightly abraded over this area. The inguinal swelling crepitated on handling, giving the sensation of surgical emphysema. There was great tenderness over the swelling, and the patient complained of intense pain in it. Next day the state of affairs was much the same. There was absolute constipation, but very little vomiting. There was never any swelling in either inguinal region prior to this injury. An aperient was ordered, also enemata, but without other effect than that of increasing the vomiting and abdominal pain. Tympany of the abdomen soon appeared, and rapidly increased. Owing to the history of the injury, the swelling in the left inguinal region associated with vomiting, absolute constipation, and increasing tympany, Dr. Nolans arrived at the conclusion that the case was one of a strangulated traumatic hernia requiring operative interference as soon as possible, and accordingly sent for me. On my arrival on the evening of the third day after the receipt of the injury, I found the skin over the left inguinal region becoming gangrenous and crepitating on gentle pressure. The scrotum was perfectly black, and quite as large as a man's head. The general state of the patient was far from promising. Vomiting during the day had been severe and almost continuous, the pain had been extreme up to that day, the tongue was dry and brown, constipation was absolute, the abdomen greatly distended, the facial appearance was one of anxiety, the pulse was quick and feeble, restlessness was marked, and he had been without sleep from the time he received the accident.

The stomach was well washed out and a little chloroform administered. Having cleaned the affected area as well as we could, a free incision was made through the skin and underlying structures giving exit to a large quantity of dark brown foul-smelling fluid, mixed with gas, broken-down blood-clot, and sloughs. On douching and separating the softened sloughing tissues, a knuckle of gangrenous gut with a small perforation in it was discovered at the bottom of the wound. It was impossible to be certain, but, as far as we could see, the bowel was forced through the muscular structures of the abdominal wall. On account of the very septic state of all the surrounding parts, and on account of the patient's general condition, I decided simply to make a free incision into the protruding piece of gut. Having done this, the wound was irrigated and the index finger passed up the opened bowel so as to ensure that the constriction was not so tight as to occlude the lumen of the gut and prevent the exit of its contents. A tube was then placed in the bowel, and gauze packed loosely around it. An opening was made in the bottom of the scrotum, a quantity of bloodclot was removed therefrom, and a drainage tube inserted. Directions were given to wash out the stomach should vomiting recur, and to irrigate the bowel with warm water next morning if the bowels did not act in the interval. A purgative was to be administered as soon as the bowels acted. The subsequent treatment of the case devolved upon Dr. Nolans and the nurse to whose care and attention at this stage the gentleman owes his recovery. There was a free evacuation next day through the artificial opening, and everything progressed in a satisfactory manner, until, at the beginning of September, on my return from my holidays, the patient was sent up to town to me to operate for the fæcal fistula, or, rather, false anus which was bound to exist. After a few days I proceeded to operate by first closing with sutures the existing opening as accurately as I could, after which the parts were as thoroughly disinfected as was possible under the circumstances. This being done, an elliptical incision was made around the previously existing opening down to the peritoneum. At this point the intervening mass of tissues was grasped with forceps, the peritoneum opened above and below, and the mass with the afferent and efferent loops of intestine withdrawn, after separating some few adhesions within the abdomen. The abdominal cavity having been protected by gauze packing, about six inches of the intestine, including the artificial anus, were resected, and an anastomosis effected by a Hildebrand's modification of the Murphy button. The wound was afterwards closed by suturing in layers with buried catgut sutures, and the skin edges united by silkworm gut, except at the scrotal end, from which too much skin had to be removed to permit of accurate approximation. Union by first intention took place throughout the sutured area. The bowels acted naturally on the second day. The button was passed on the ninth day and the patient left for Gorey in less than a month, and has since then remained in perfect health.

(a) Paper read before the Dublin Biological Club, February 21st, 1905.

The interest in this case centres round two points, the first being the nature of the hernia, which must be described as traumatic, a form of hernia which is extremely rare, there being practically no mention made of it in any of the textbooks with which I am acquainted, while any reference made to such a condition is directed particularly to the diaphragmatic variety; the second point of interest being the method of dealing with a herniated gut undoubtedly gangrenous when exposed by operation. With regard to gangrene, a further question for pathologists arises, viz., whether the mechanical arrest of the circulation is the only element of importance in leading to its production, or whether gangrene does not more largely depend upon organismal virulence and activity. Not unfrequently a surgeon cuts down upon a hernia strangulated for two or three days and yet finds the gut in such a condition that he returns it without a moment's hesitation, while on the other hand, he has occasion to operate upon a case in which the strangulation has existed for perhaps less than twenty-four hours, and apparently no more tightly than in the former case, yet the condition of the strangulated gut is one almost, if not quite, gangrenous. Such a diverse state of affairs would surely serve to point to other factors than mere mechanical interference with the circulation, being of etiological importance in leading to the production of intestinal gangrene.

Before coming to the treatment of undoubtedly gangrenous gut when exposed in the sac of a hernia, I should like to ask for information from those members of the club whose experience is greater than my own, how they finally solve the problem as to what is to be done in those cases which are in a decidedly doubtful state, and which embrace, so far as my experience goes, by far the largest proportion of cases one meets in practice. My own practice so far as tests are concerned is to employ warm saline irrigation, after dividing the constriction and withdrawing the loop, and notice whether the circulation returns as shown by change of colour. The gut is also flipped with the finger or handle of the knife and peristalsis watched for. It is particularly noticed whether the peristalsis thus excited, travels beyond the area of constriction. The veins in the mesentery leaving the loop are also examined to see whether they are thrombosed. Of course, the site of constriction is examined the moment the gut is freed, also the most distal part of the loop. In spite of these tests, I have often found extreme difficulty in deciding whether the loop is likely to recover, and consequently what should be done with it. Hitherto, I have always returned the loop in such cases just within the internal abdominal ring, merely closing the skin round, and in no case have I had occasion to regret this step. The abdominal cavity seems the best place to ensure the recovery of a doubtful piece of intestine. It is, I think, unquestionably the case that many unnecessary resections are performed in such cases, and few will be found to deny the fact that resection will add, to place a mild estimate upon it, at least 20 per cent. to the mortality of the operation for strangulated hernia. As regards the treatment of undoubtedly gangrenous hernia, I do not think any surgeon would be so unwise as to lay down a hard and fast rule which he would make applicable to all cases. For example, to have resected the gangrenous loop and opened the abdominal cavity to perform an end-to-end anastomosis in the presence of a mass of septic sloughing tissues such as I had to deal with in the case already detailed, would, in my opinion, have meant disaster.

Again, resection, followed by anastomosis, considerably prolongs the time occupied by the operation, and many such patients are not in a fit state to withstand prolonged operations. To leave a large gangrenous loop in the sac of a hernia—merely making an incision into it—would undoubtedly be unwise, as the increased septic absorption therefrom would surely add the last straw to the patient's already overtaxed recuperative powers. In such a case, if the patient's condition is one of gravity, resection of the greater portion of the affected loop, as it lies in the sac of the hernia without touching the constricting band, would probably be the line of treatment from which the best results might be anticipated. Resection and immediate restoration of the continuity of the intestinal canal should, in my opinion, only be undertaken where, in the first place, the patients' condition is otherwise good, and secondly in cases in which perforation has not yet taken place, and, consequently, in which the gangrenous process has not spread to the surrounding tissues, no matter whether the affected loop be large or small. The treatment of the affected area in cases of partial enterocele, of which I have met with three examples in the sac of a hernia—two of which occurred in successive weeks—is always one of considerable anxiety, when the ensnared portion involves more than one-third of the circumference of the bowel, but if less than this amount is involved the difficulty is easily overcome by enfolding the affected area by a purse-string suture, and applying a couple of Lembert sutures over this again, at right angles to the long axis of the intestine.

One other question arises in connection with gangrenous hernia, viz., should a radical cure ever be attempted in cases in which resection and immediate anastomosis has been performed. My own reply would be certainly not. Sepsis is pretty certain to occur in the wound, and the attempted radical cure will be a failure.

To sum up, I should say that in all doubtful cases of partial enterocele involving one-third or less of the circumference of the bowel, the affected area should be enfolded and the loop returned into the abdomen. In all doubtful cases of partial enterocele involving more than one-third of the circumference of the bowel, the treatment should be the same as that for ordinary doubtful cases of strangulated hernia—that is, return the loop just within the internal ring.

In undoubtedly gangrenous partial enteroceles involving one-third or less of the circumference of the bowel, enfolding the gangrenous area by a purse-string suture reinforced by a Lembert suture applied over it at right angles to the long axis of the gut, would appeal to me as the proper course to adopt, while, should the gangrenous process involve more than one-third of the circumference of the bowel, resection of a couple of inches of the bowel followed by immediate anastomosis (lateral or end-to-end, as the case may be), if the patient's condition is otherwise suitable, should be adopted. If the patient's condition is not considered suitable for immediate anastomosis the loop should be withdrawn, the gangrenous portion cut off and the ends drained by Paul's tubes.

In either large or small gangrenous herniæ, if the loop has not perforated, if the gangrenous process has not spread to the surrounding tissues, and if the patient's condition is suitable, resection, of not only the affected portion but of a considerable portion both above and below the area of constriction, followed by immediate anastomosis, should be performed.

In small, gangrenous herniæ, which have perforated or in which the gangrenous process has spread to the surrounding tissues, or in which the patient's condition is bad, a free incision into the affected loop without interfering with the constriction will give the best results.

Large gangrenous herniæ, which have perforated, or in which the gangrenous process has spread to the surrounding tissues, and in which the patient's condition will, in all probability, be extremely grave, are best treated by cutting away the greater portion of the gangrenous loop, and leaving the wound open for free drainage, the constriction being left untouched.

The Out-Patient Departments.

SALFORD ROYAL HOSPITAL (PENDLETON BRANCH).

Summer Diarrhœa in Infants.

By Stanley Hodgson, M.D., B.S.Lond.,
Hon. Physician.

Although in the vast majority of cases the children who are the subjects of this scourge have little or no stamina with which to resist its attacks, yet occasionally one happens on a well-developed and previously healthy child in whom active measures are sometimes fruitful. One is then struck by the hopelessness of the usual methods employed when the patient is not treated in hospital. Much of the procedure is admittedly impossible under the conditions which surround the sufferers in their homes, but it is open to question whether the most is made of the resources available even to the poorest. The death of these infants is due, not so much to toxic absorption, as to collapse from the relatively enormous loss of fluids. The free watery diarrhœa and the copious vomiting quickly drain the organism of all its spare fluid and the rapid, feeble pulse is a physiological result of this desiccating process. It is hopeless attempting to supply the deficit by the mouth, and subcutaneous or intracellular infusion is only possible in skilled hands. But there remains the rectum. There is always someone in the very poorest quarters who possesses an enema-syringe, and no child should be allowed to end in collapse without some attempt at supplying the necessary liquid in a rational manner. As an example of what can be done in this direction, a child of eleven months was brought to my out-patients' department in the sixth day of diarrhœa. The child was obviously what the mother described as a "fine baby," but it was equally obviously very near death. The mother had tried every variety of food, including albumen water. The vomiting and diarrhœa had in nowise abated. The child was almost pulseless, the muscles were flabby, the abdomen shrunken, and the eyes "hollow." The child had not sufficient energy left to resist palpation of the abdominal viscera. Salicylate of bismuth with tinc. camph. co. was ordered, more with a view to gaining the mother's confidence than in any hope of its efficacy. The belief in medicine as such is very deeply rooted in the poorer classes. It was directed that in the event of the medicine being vomited it was not to be repeated. The condition of the patient was explained to the mother, and she was told that the only hope for the child lay in its retaining water given rectally. All feeding was absolutely forbidden and the giving of water by the mouth was also barred. The mother was told to wash out the child's rectum with warm water and then give half a pint of isotonic saline solution (90 gr. to Oj.). She was told to do her utmost to prevent this saline being returned, and to repeat the injection in four hours' time. The mother carried out the instructions to the letter, with the gratifying result that in four days the child was practically well. An ordinary rubber enema-syringe, borrowed from a neighbour, was used for the injections.

This case was very striking. No drug treatment, brandy or strychnine, could possibly have helped the heart, which was failing for want of fluid resistance. But the first half-pint of water that was absorbed effected a visible improvement.

Special Articles.

EARLY HISTORY OF THE MEDICAL PROFESSION AND OF HOSPITALS.—II.

Medical Science in the Second Century.

Immediately preceding the era of Galen, medical science had succumbed to the deplorable influences of contentious and zealous sects. Galen's advent arrested the complete downfall of medicine as a scientific method of cure, and maintained through his authoritative exposition the outlines at least of treating maladies for centuries upon the basis of a reasoning philosophy. Born in the city of Pergamos, in Asia Minor, towards the close of the first portion of the second century, he began his useful existence amid the cultured surroundings of a municipality long celebrated for its temple dedicated to Æsculapius, the colossal dimensions of a carefully selected library, and its school of medicine. In the scientific treatment of his medical essays he unequivocally asserts that he is totally disconnected with and unattached to any of the numerous sects which divided the profession of his day.

The Galenic system of medicine thus established by the practical skill of its founder upon the most accessible materials which intelligent zeal could use, was so servilely followed throughout the Middle Ages in a deteriorated adaptation, and conjoined with the assumed potency of external but divided influences, that a short outline of the same is necessary. According to this methodical treatment of medicine, there were in man three principles or actuating impulses—spirit, humours, and solids. Inasmuch as he accepted the dynamical forces of the soul, or pneuma, with Hippocrates, he also admitted the four primordial qualities of heat, cold, dryness, and humidity, which in their individual or united action, sufficiently influenced the transformation of the human system. He owns three original powers—natural force located in the liver, vital force in the brain, and sensual force in the heart, which were vitalised in their respective habitations by a concealed pneuma or soul. These natural essences, which directly supervise the action of production, nutrition, and growth, in their turn are controlled by four—the attractive, differential, preservative, and exclusive powers, and collectively act under the domination of a circulating spirit which moves through the arteries and have their central organism in the liver, where the veins originate, blood is prepared, and nutriment distributed to the entire body. From the character of Galen's distribution of the sanguinary fluids throughout the veins, it is a rational conclusion to assume his practical acquaintanceship with the circulation of the blood, to whose knowledge the utility of venal valves was alone essential to complete the universality of his anatomical learning. In addition to pagan philosophy, Galen was well versed in the doctrines of Moses and in the religion of Christ; but the partial obscurity of his superstitious deism induced him to sneer at their teachings. To what extent the treatises of Galen may be of practical service in modern times, they must be awarded the high commendation of securing subsequent medicinal art from total wreckage during the turbulency of the Middle Ages, and assisted at its revival into an embellished science through the mediæval Universities. From the time of Galen to the close of the sixteenth century, the works of the Pergamic sage fully satisfied the demands of the practitioners of medicine, who depended on his surgical and anatomical writings, without questioning their authority.

Chemistry and Mediæval Pharmacy.

Of all appliances closely identified with medicinal art, the one rendering the most signal returns for efforts strenuously devoted to penetrating and exploring the secrets of nature, and boldly appropriating the principles thus obtained to scientific curatives, alchemy is certainly entitled to unstinted laudation. Out of that burning frenzy of mediæval alchemists and astrologers to fabricate the "philosopher's stone," arose, towards the fifteenth century, the exact science of chemistry, and from absurd notions of astrology originated a more perfect astronomy. Alchemy, vigorously pursued with unremitting energy by illustrious scholiasts, and after the accumulated learning of years pronounced by a famous scientist to be a mendacious fraud, in its medical association, may justly claim the high commendation of establishing that system of extracting essential principles from metals or minerals, whose energetic forces abundantly assisted the cure of maladies. Whether derived directly from Arabic sources, or traceable to Egyptian hierarchy, as a portion of those hidden sciences exclusively possessed by the ancient priesthood, doubtless its medicinal adaptation should be awarded to the Saracens.

It would seem that the Christian clergy of an early age understood sufficiently the operations of chemistry to be able to control the results of the judicial hot iron and water adopted as tests of enormous crimes. The general principles of this science were certainly known in Diocletian's time, by the order of whom Egyptian books on this subject were given to the flames.

Perhaps the highest practical discovery of these pharmacists was that of the essential force of aquafortis, by whose solvent virtues brass or copper was readily separated from gold or silver. This system of purging valuable metals from useless dross was utterly unknown to the ancients, according to the utterances of an illustrious jurisconsult, who declared when brass became amalgamated with gold it was impossible to separate them. Chemists in the Middle Ages were so profoundly skilled in these operations, disuniting the elements indicated, that oftentimes silver in alloy, when disintegrated, under the soluble virtue of aquafortis, ascended in columnar shape, emitting variegated colours, and when thoroughly washed, and nothing of this substance was visible in a vase of water, the pure gold was found resting at the bottom. An additional purifying element, largely used in those ages, was the cupella, fabricated by a chemical process from bones, which enabled gold and silver smiths to purge their wares of every particle of impurity or alloy. It appears to have been operated by covering the finer metals with laminated sheets of lead, beaten very thin, and placing them in a crucible exposed to intense heat. When liquefaction had melted these substances, the above preparation was mingled with the molten mass, which caused a precipitate of pure gold, and denominated "Aurum de Cupella" by Italian alchemists.

Processes of distillation were used at remote periods of the Middle Ages in order to procure medicaments in such suitable and attractive forms as to admit of readier acceptance by the sick. Among these may be designated the aqua vitæ, or eau-de-vie, as its name implies, life-potion; oil of cinnamon and herbal extracts, such as chicory, &c., with precipitates in the nature of medicinal salts—all were applied to the cure of diseases. The preparation of these oils and waters is certainly traceable to the year 1080. In the year 1160, Mesne had already made distillations of absinthe and rose-water. To Villannova, should be accorded the praiseworthy adaptation and first precise description of eau-de-vie, or brandy, prior to the end of the thirteenth century. In his treatise on the preservation of youth, he explicitly states that the virtues of this potion were already fully known to many by actual experience. Then, describing its amazing properties, Villannova exclaims: "Who would believe that from wine can be extracted a fluid which requires different processes, having neither the colour, nature, or effect of wine? This eau-de-vie, or life-potion, abundantly justifies its name, since it prolongs human life." Rival physicians of the fourteenth century exhausted the entire range of panegyric in order to enlarge the use of eau-de-vie as a medicament. So great, indeed, was its celebrity, that before the conclusion of the era mentioned it came to be regarded as a universal remedy, and applied indifferently, either externally or internally. This liquor was prescribed for a malady of Charles the Bad, King of Navarre, and, by a singular casualty, caused his death in the year 1387. In order to rejuvenate this exhausted royal libertine, physicians ordered him to be wrapped in linen bandages saturated with brandy sewed closely to his body. A servant charged with this duty, lacking scissors to cut the thread, sought to sever it with a lighted taper; instantly the inflammable texture was fired, and quickly terminated in inexpressible agony the life of this prince, stained with infamous debauches.

In the Italian monasteries, and doubtless elsewhere, until after the Middle Ages, the conventual pharmacies were well supplied with this active stimulant, used almost exclusively in grievous maladies, and prepared by the monastic distillery. As usual in the administration of remedies to the poor, this medicine was freely given to the impotent and impoverished, consequently large quantities were ever ready for emergencies. The persons entrusted with the custody of curatives or medicaments in the cloister pharmacy were distinctively named from an early period as apothecaries—a service of so great importance as to receive from time to time, specific regulations by the principal church synods.

Hospitals in the Middle Ages.

From the monastic infirmary and hospitium was developed a system for the regular aggregation and treatment of sickness and diseases under rules and ordinances whose careful execution contributed to practical mediæval philanthropy. In that signification, this department of conventual organisation is of high antiquity, and as early, indeed, as the age of Charlemagne, such separate apartments were used exclusively for sick persons. They afforded a practicable means of exhibiting in practice the fundamental principles of conventual charity in providing food for the impoverished, lodging for the houseless, and medical treatment for diseased strangers. By whatever series of eventualities this monastic institution passed from the strictest interpretation, and survived as a hospital, or edifice entirely set apart for reception and cure of maladies, may perhaps be gleaned from notions touching its more ancient purposes, which, under ecclesiastical manipulation, necessarily were remodelled towards the end of the twelfth century. In the year 1059, a hospital exclusively for sick girls had long been extant at Durham.

At a much earlier period, however, there were organisations of this character among the Spanish Arabs, together with poor-houses solely occupied by the indigent and pauper people, entirely supported by public funds, in the year 976. When Benjamin Tudelensis was at Jerusalem in 1173, the Christian people maintained an institution of this character exclusively for their own sick. Eight years later, Roger de Moulin promulgated a series of regulations for these eleemosynary organisations in this city, which may have been suggested by earlier rules. By these ordinances, each hospital should have four physicians skilled in diagnostics, pharmacy, &c., and a like number of surgeons. To these were added nine *sergens*, or assistants as menials, to provide ready service for the feeble and wounded.

Knights of the Hospital Order, whom these regulations principally controlled, were detailed to a day and night watch over the sick, and, indeed, for this attendance the hospitallers of either sex were liable. For ready use syrups or electuaries were applied as potential curatives. These compounds, it has been stated, were unknown to the Western monasteries at this period, and their existence in this venerable ordinance attests the rapid appropriation of Arabic drugs by crusading adventurers.

In the form of gratuitous attendance upon the sick and diseased, the Eastern Arabs in the eighth century possessed a regularly organised system of public infirmaries in the great metropolis of Bagdad. In the time of Benjamin, the Hebrew traveller, A.D. 1173, a most efficient and practicable scheme had long existed in this city, for the reception of the disabled and infirm poor into hospitals thoroughly equipped with sixty salaried physicians and completely furnished with pharmaceutical supplies. But transcendent and above this form of philanthropic benefaction, called into existence by enlightened Moslem economy, was a most thorough organisation of a public establishment at Bagdad for the custody and care of the insane, brought thither from all parts of the Persian empire. Here the inmates were subjected to scientific medical treatment until sanity was restored, when the patient returned to his domicile, where he received professional attendance for several months to prevent a relapse into the malady of which he was cured.

Hospitals for the sick, orphanages for foundlings, and great institutions for the proper care of paupers, developed with immense strides, under the thoughtful and judicious zeal of their founders, and during the twelfth century expanded into gigantic proportions. In the ensuing age, the mediæval mind was fired with a faith in the efficacy of unstinted charity, members of society from the Holy Pontiff himself to the humblest cloistered recluse by the wayside, rivalled each other in gratuities of food and clothing, founding of hospitals and endowment of beneficent public institutions. St. Louis' highest claim to pious glory arose from his restless and unstinted charities to the indigent and sick. The intercourse of this king with the diseased in hospitals, where he entered to administer personal consolation, utterly oblivious or indifferent to the dangers of such nursing, may be taken as an important attestation of the extension of this virtue toward benevolent enterprises during the Middle Ages. The internal arrangements and thoroughly practical nature of the ordinances to which the mediæval hospitals owed their existence, excite surprise and demand unreserved admiration.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, August 26th, 1905.

Indications of Digitalis.

Hitherto it was taught by authorised clinicians that digitalis had a beneficent action on mitral lesions of the heart, alone; that in all other cases of cardiac disease, especially in aortic lesions, it was useless or dangerous. But recent experiments have shown that digitalis was useful in every case of weakness of the myocardia (symptomatic asystolia) whether due to organic lesion of the heart or from chronic disease of the respiratory organs, such as emphysema, chronic bronchial catarrh, well known to provoke cardiac asthenia.

Asthenia of the heart can be also the consequence of interstitial nephritis of arterio-sclerotic origin at the period when the hypertrophied myocardia degenerates, accompanied by dilatation of the heart. In such cases the administration of digitalis can raise the tone of the head.

The same cardiac insufficiency is observed in the course of infectious diseases and wherever there exists general depression. It can follow the abuse of coffee, tea, alcohol, and tobacco.

According to Eichhorst, digitalis is the surest remedy we possess against persistent cardiac asthenia.

As to the mode of administration of digitalis, Prof. Eichhorst employs exclusively the powdered leaves, but he associates with it diuretine (salicylate of soda and theobromine):—

Powdered leaves of digitalis, 2 grs.;
Diuretine, 16 grs.;
Sugar, 6 grs.

For one wafer. Three daily, and continued ten days. By this means the patient takes 2 grains of digitalis three times a day, which constitutes the dose for an adult; with smaller doses the effect desired is not obtained, while larger doses might provoke anorexia, nausea, vomiting.

In certain cases of arterio-sclerosis of the arteries, tabagism, alcoholism, or gout, one or two wafers daily should be given, and continued, without interuption for weeks. In cases of dyspnœa and cyanosis it is frequently necessary to associate with digitalis, stimulants—brandy and water, champagne, injections of camphorated oil (10-100). The effects of the digitalis are shown by an increase in the diuresis. The quantity of urine in twenty-four hours rises to two quarts, and sometimes much more, and where œdema or dropsy is present it is absorbed.

While the patient is submitted to the treatment, he should be carefully watched by the medical attendant. Immediately the pulse falls below 60, the treatment should be suspended, otherwise the patient would be exposed to certain accidents: lypothymia, cerebral troubles, Cheyne-Stokes' respiration, &c.

Treatment of Erysipelas.

The best treatment, according to Prof. Robin, consists in spraying the parts with a warm solution of bichloride of mercury at 1-1,000, with 20 grains of tartaric acid added to each litre to prevent the formation of albuminate of mercury. The steam apparatus should be employed when possible, and held about a foot and a half from the face of the patient. The eyes should be bandaged and the mouth kept closed. The pulverisation should last from twenty to thirty minutes, and be renewed six or eight times during the first day, and also the following day, if improvement have not taken place. Generally on the third day a manifest improvement is observed, when the number of séances may be reduced, and so on until the end of the malady.

The treatment by warm antiseptic solution is simple in its application, free from danger and remarkably efficacious. The general treatment consists in milk diet, and the administration of tonics :—

Ext. of cinchona, 1 drachm ;
Brandy, 1 oz.;
Gum julep, 4 oz.

A tablespoonful every hour. In no case of erysipelas should rinsing of the mouth and nasal irrigation be forgotten :—

Naphthol, 4 grs.;
Borate of soda, ½ oz.;
Peppermint water, 4 ozs.;
Boiled water, ad one quart.

Lotion for urticaria :—

Thymic acid, xv.;
Phenic acid, xxx.;
Proof spirit, 6 ozs.

Rub the parts with absorbent wool moistened with the mixture.

Germany.

[From our own Correspondent.]

Berlin, August 26th, 1905.

The Diagnostic Importance of Some Skin and Tendon Reflexes.

During the last thirty years some of these reflexes have reached a high stage of importance, the value of which has been clearly set forth in an article in the *Fortsch. d'Medizin*, by Hr. M. Rothmann, Berlin. Amongst the reflexes studied those of the Achilles tendon are not the least interesting and important. The reflex of special importance is that in commencing tabes, whilst the patella reflex is still retained the loss of it in one or both tendons of Achilles, will render the diagnosis certain. Frequently, when the Achilles tendon reflex is absent the plantar reflex may be produced by tapping the gastrocnemius, distinct evidence in favour of the spinal reflex theory (Erb) as opposed to the muscular theory of Westphal. The question as to whether tendon reflexes can be produced when the brain is entirely separated from the spinal cord must be decided in the affirmative.

The skin reflexes are much more complicated than those of tendons. Whilst we are far from being acquainted with the reflex tracts in the human subject, the author has succeeded in mapping them out in the dog. Babinski's reflex is very important. Strong dorsal flexion of the toes, especially of the great toe, when the skin of the external margin of the foot is irritated. It renders certain the diagnosis of organic spastic as opposed to fundamental spastic paralysis (hysteria). In weakening of the over-powerful influence of the cortex of the brain (spastic diplegia, epileptic coma, pseudo-bulbar paralysis, removal of the brain in dogs), or touching the hard palate of dogs, their lips, tongues or other parts of the mouth. Rhythmical movements of the lips, tongue, and muscles of mastication take place, which are to be looked upon as movements of tasting, sucking, chewing, and swallowing. It is plain that here old phylogenetic relationships come again into play, now that the cerebrum is partially or entirely removed. The author believes that further inquiry into the field will lead to great results, not only to the neurologist but to the practitioner.

Fatal Poisoning with Balsam of Peru.

Such cases are exceedingly rare, and the one reported by Dr. Deutsch in the *Zeitsch f. Med. Beamt.* is interesting not only for its rarity, but as an illustration of the ravages of quackery.

Four children of the peasant class, of ages from 5 to 13, became affected with scabies. A quack basket-maker was consulted. After seeing one of the children he declared the illness to be a bad itch and ordered a blood-purifying tea, and after that an ointment prepared by himself to be rubbed in. The last procedure caused sores on the skin and great pain. On this being reported to the basket-maker he ordered balsam of Peru and sulphur in a wash ; after the bath the balsam was to be painted on the sore made by the ointment. This treatment was kept up for several days. One of the children, and the strongest, a boy, æt. 11, then had swellings in the eyes, hands, and feet, and could pass but little urine. When this circumstance was communicated to the quack he ordered senna tea with liquorice and juniper and said that the condition was not bad (nicht fur schlimm). But as the condition of the boy got worse the two younger brothers also showed signs of swelling, and the writer of the paper was called in. The three children were admitted into hospital, and the eldest was already unconscious and died in uræmic convulsions the same night, in spite of all that could be done ; the two others recovered. In all three children the urine was albuminous more or less ; it contained cylinders, both hyaline and granular, and both red and white blood corpuscles.

The post-mortem examination showed œdema of the skin and distinct nephritis, in addition to traces of scabies.

The quack was summoned and tried. Nothing could be ascertained as to the composition of the ointment. He received a sentence of six weeks' imprisonment for culpable negligence—the negligence lying in the fact that even after the swellings had made their appearance he persisted in the use of the Peruvian balsam. The case should certainly serve as a warning, as it appears that really very little Peruvian balsam was used. Unfortunately the report does not give the number of sores, nor the extent of surface covered by them.

The *Deutsch Med. Zeitung* relates a case of

Anuria with Recovery

by Dr. Moschkowitz.

The patient was a man, æt. 48, who was admitted into hospital on November 25th, 1903. For about five years he had had pain in the right side of the abdomen. That had been supposed to point to appendicitis. During the last two years he had several attacks of lumbago. On November 15th he had a violent attack of pain in the region of the right kidney ; that required repeated subcutaneous injection of morphia. Early on the morning of the 22nd, urine ceased to be excreted. The patient vomited several times, he complained of nothing more, however, but the idea tormented him that in spite of all his efforts he could not empty his bladder, but he felt no desire to micturate. Palpation was not practicable owing to obesity. A diagnosis of calculous anuria was formed, and an operation was performed within 48 hours of the setting in of the suppression. Nephrotomy was performed, and a stone found in the pelvis of each kidney, and also an obstruction in the ureter about six inches from the skin incision. The perirenal fat on the left was œdematous. Notwithstanding the desperate condition of the patient he rallied quickly, and from the next day the urine came away so freely that in spite of frequent change of dressing he lay in a lake of urine. On December 29th the condition had become sufficiently favourable for further treatment. A bougie showed obstruction in both ureters, about six inches deep on the right and seven on the left. The blocking was so complete that fluid injected into the ureter immediately returned. On cystoscopic examination it was imagined that a calculus could be seen embedded in the mouth of the left ureter. Examination by X-rays was unsatisfactory. On January 14th, further operation was proceeded with, and in lieu of the appearance of a stone in the mouth of the left ureter epicystotomy was performed. No stone was found, but the opening of the bladder was made use of to pass bougies into both ureters temporarily. Then the right ureter was exposed to the right of the extraperitoneal incision, a concretion the size of a large date stone was found above the liver arcuata and removed. The wound in the ureter was closed by catgut sutures and the abdominal wound sutured in layers. Drainage with strips of iodoform gauze. Union took plate by first intention and on the first day 130 c.cm. of urine were passed naturally. The patient recovered so rapidly that a further operation could be performed on the fourteenth day. This was exactly like the former one, except that the calculus was smaller and it lay an inch deeper. and consequently took more working out. Union by first intention again took place. The wounds into the two kidneys also healed rapidly, so that the patient could be discharged by February 10th.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 26th, 1905.

DANGERS OF VENOUS ADRENALIN INJECTIONS.

FISCHER told the members of the Wiesbaden Congress that he had been operating on guinea-pigs and other animals with injections of the suprarenal body which produced hard patches and aneurysms in the aorta. Closer investigation prove the smooth middle coat to be necrosed in patches, subsequently becoming calcified, and associated with bands of broken degenerate elastic tissue.

The order of pathological change seems to be, first mesarteritis destroying the arcus aortæ and aortæ thoracicæ and finally closing with the endarteritis. In the heart myofibrosis, myocarditis interstitialis with sometimes calcification of the cardiac muscles. Sometimes the animals are attacked with varying forms of apoplexy. When this pathological change in the arteries is not so far advanced the toxic substance carried into the system by the venous injections produces a sort of cachexia of a fatal character. The question that occurs to us, is the arterio-sclerosis in the animal the same as that met with in the human subject? In the former it seems to be a poison that produces necrosis and may thus differ histologically. There is some peculiarity in the difference of tissue as this arterial change was not observed if the drug was injected into the subcutaneous tissue, neither did it occur in the vessels of dogs when injected intra-venously, although it did in guinea-pigs. It would seem that different animals have different reactions.

Külbs said he had experimented on animals also with the suprarenal body and found that after single doses of an adrenalin injection sclerotic changes could be found in the aorta. but never in the peripheral vessels.

Albrecht remembered similar results he obtained some time ago when experimenting with this substance on animals, and passed it over as the aortitis luetica of man, as casually looking at it gave that impression.

CHEMICAL PRODUCTS IN CHRONIC NEPHRITIS.

Rumpf gave the results of 2,000 analyses of the blood with the object of deciding the controversy whether sodium chloride is burned up in nephritis. It may be that a large number of the nephritic cases may have a large amount in the diseased kidney, and that a large accumulation of sodium chloride produces œdema and becomes a check to diuresis, thus eliminating less chloride of sodium than the healthy kidney. There are cases where the opposite prevail, thus pressing us to the conclusion that the increase or reduction of chlorine has no specific effect on nephritis or its eliminating power. He agrees with other observers that when the kidneys begin to shrink the solids are increased and the fluids diminished, and that at different stages some constituent of the urine may be suppressed. He is not satisfied with our present estimation of chlorine calculated as sodium chloride, as the acids and bases do not accurately give a true estimate of the final salts. In disease a large amount of ammonia is present in the different organs which it is necessary to estimate. In hepatic cirrhosis he found, as other investigators, an increase of 13 per cent. NH_3, in chronic nephritis it was 9 to 13 per cent., giving about 1 gramme of ammonia in the 24 hours. Now, by feeding and giving sulphates with acid phosphates of ammonia the salts are transformed and broken up, leaving the acid for elimination as before, while the blood is deprived of sodium and enriched by chlorine. Rumpf believes that a similar reaction takes place between ammonia and chlorine.

INFLUENCE OF TEMPERATURE ON SUGAR ELIMINATION.

Lüthje told the Congress that external temperature had a wonderful effect on the elimination of sugar in the diabetic. He wounded the pancreas in dogs and kept them in rooms of different temperatures. When the temperature was high less sugar was eliminated, when low it was increased. This, he thinks, will be of therapeutical value, as the elimination of albumen is unaffected. This fact, he thinks, confirms Rubner's theory on the thermal splitting of the albuminoid molecule into nitrogen free and nitrogen fixed. How far this high or low temperature may be carried in the treatment of the diabetic is yet a matter of speculation, but Lüthje thinks worthy of experiment.

Klemperer said that he had often observed this fact in patients he had sent to Carlsbad, as they never recovered so well in the winter as in the summer. These experiments also proved the utility of keeping the patients warm in bed and giving alcohol in several cases.

Embden supported Lüthje in affirming that he had experimented in the same manner with dogs and had obtained similar results. He had gone further in his operations by wounding two large dogs which he had hungered and kept under similar temperatures. The daily output of sugar was similar in both cases when exposed to different temperatures.

LUXATIO TESTES.

Jurinka relates a very rare case of dislocation of the testes. The patient fell from a waggon and displaced the testes into the hip joint. Laparotomy was performed immediately after, and the flattened testes found between the ends of the bones in the hip joint. Castration was performed, the wound drained, and the patient made a good recovery. Such a luxatio femoris præcotyloidæ has nowhere been recorded. The hip joint seems to have been dislocated and the testes thrown between the heads of the bones, where they became entangled.

Hungary.

[FROM OUR OWN CORRESPONENT.]

BUDAPEST, August 26th, 1905.

AT the last meeting of the Budapest Royal Society of Physicians and Surgeons, Dr. Kombi read a paper on

RENAL LITHIASIS IN INFANCY.

During the last two years the reader has made 160 necropsies, and has observed at least 70 cases of renal lithiasis in one form or another in nurslings. Amongst these there was not one case of biliary calculus. Renal lithiasis may occur in the form of uratic dust which may be observed as yellowish striæ in pyramids.

Gravelly concretions and calculi are also found, and in some cases may be observed during life in the urine, especially in extreme cases of inanition and malnutrition. A condition known as inanition fever has been described by American practitioners, and is found in newly-born children who do not receive a sufficient supply of milk or fluid nourishment. This fever is to be attributed to the deposition of uratic material in the kidney, though no evidence may be found in the urine. Bokay points out that normally, during the first few days of life, the urine is extremely rich in uric acid, and that by the end of the second week its more usual characters are assumed. The reader has more particularly observed 23 cases of which 14 were boys and 9 were girls. The majority of the cases occurred under the age of six months, and all were due to bad feeding, inanition, and "misère physiologique." Of the total number 20 were reared by hand. In addition to the uratic dust observed in the pyramids, gravel and hard calculi, angular or rounded in form, were found in the pelvis of the kidney and the calices. They consisted of urate of sodium, and it is possible that troubles arising at a later period of existence may have their ultimate origin in such early formed calculi. In some instances pyelitis or hydronephrosis was observed. The symptoms were obscure as the regular signs of renal colic were absent. Crying, general uneasiness, screaming during micturition or retention of urine may all be symptoms. The prognosis should be reserved. Fatal results may follow; in case of survival, renal colic, cystitis or vesical calculi may occur.

Prophylactic treatment should be observed in insisting on ample and proper nourishment at the earliest period of life, although overloading of the stomach should be avoided. Weaning should not take place too soon, and during febrile attacks plenty of water should be given to facilitate the excretory action of the kidneys. If the stomach be extremely intolerant of food, &c., lavage of that organ or injections of artificial serum may be employed. If the lithiasis be confirmed the child when older may undergo a "cure" at the corresponding baths.

Koplik's Spots not Constantly Present in Measles.

Rolli has looked for the spots on the buccal mucous membrane, first described by Kōplik as preceding by some days the general eruption of measles, and has found them in 24 cases. In one case they preceded the eruption by six hours, in 11 cases by one day, in 5 by two days, in 3 by 1¼ days, and in 2 by four days. The spots were generally situated on the mucous membrane of the cheeks opposite the molar teeth, but occasionally on the lips—beginning as slightly raised, bluish-white, circular, sharply-defined points, in size less than a pin's head, and surrounded by a narrow red areola. In a few days they generally increase slightly and become more prominent, and the areola enlarges and becomes more irregular in outline. Their number varied between 6 and 20, and the time during which they persisted from two to six days. They were not marked just before, or at the time of the general eruption. They were not present in 14 cases (17·1 per cent.). Since they are never seen in other conditions accompanied by fever, they are of the greatest importance for the early diagnosis of measles. Rolli claims that the buccal eruption in measles was first mentioned by Gerhardt, and that their importance was recognised by Filatow in 1895, a year before their independent discovery by Kōplik.

The authorities at Cambodia in French Indo-China have decided to establish at Phom-Penh a general hospital and a lying-in hospital for natives. The work of construction will be commenced immediately.

A contemporary medical journal suggests that an appeal should be made to the Home Secretary to order an immediate inspection of the mortuaries attached to London hospitals and medical schools, urging that at some of them the existing arrangements are fraught with danger to medical students and teachers.

Continental Health Resorts.

[From our own Correspondent.]

BADEN-BADEN AND THE BLACK FOREST.

Baden-Baden continues its popularity! This is natural considering the abundance of attractions for all classes of visitors and all nationalities. It is the most French-like of all German resorts in its appearance, and in the characteristics of its truly cosmopolitan *habitues*. In its management care is shown to provide for the tastes of many guests. Its races have long been famous. Its tennis-lawns among the best known for position and condition. Now its Golf-links have (thanks to private liberality and able control) a cosy club-house; and, a point golfers should never overlook in choosing a temporary home, these grounds are the most easily accessible from the town of all Continental links.

The Reading-rooms at Baden are especially convenient and well supplied; the theatrical entertainments and concerts (in and out of doors) remarkably artistic. The hotels are unexcelled anywhere; and the society, both native and foreign, is of the best. A quiet, aristocratic, well-assured tone marks the whole place. As an enduring basis for its high position and its future prosperity Baden-Baden rests upon the intrinsic merits of its Mineral Springs, the acknowledged repute of its physicians, the skilful management and scientific perfection of its State Bath establishments and its medical institutions. Among the latter may be mentioned the private Sanatoriums, Groddeck, Frey and Gilbert, and Ebers.

The thermal waters (used for bathing, douches, irrigations, and drinking), vary in temperature from 110° to 157° Fahrenheit; their most important components are the chlorides of lithium and sodium, and arsenic; and their efficacy is unquestionable for rheumatic gout and stomachic complaints.

The location (650 feet above sea-level) at the entrance of the Black Forest is most picturesque and healthful, the public grounds and avenues are very agreeable, and the vicinity in every direction is charming.

The annual visitors exceed 70,000; and for their accommodation are an abundance of capital hotels, pensions, and apartments. Among the principal hotels are the Angleterre, Bellevue, Europe, France, Holland, Messmer, Minerva, Park, Regina, Russia, Stephanie, Victoria, Zahringerhof, &c.

Freudenstadt.—At 2,000 feet altitude in the Wurttemburg section of the Black Forest, Freudenberg, is regaining its old-time popularity. Like many German resorts, during the acrimonious days of the Boer War many of its old clients went to other summer homes; but with this era of better international feelings, British visitors are again seeking in annually increasing numbers the attractive and salubrious regions of the Black Forest. To those desiring a restful sojourn, or to recuperate over-worn energies, for the convalescent and contemplative, for the lovers of Nature, and of the forest landscapes, Freudenstadt can truly be highly recommended. Especially in these September and early October days, when pleasure trippers of July and August have gone home. For the disciples of Izaak Walton the trout streams here are captivating! The pine forests in this district, vast dark fir woods, intersected by blithely flowing streams and deep green glades, are widely noted for their beauty and healthfulness; affording with their numerous foot-paths every facility for the fashionable Continental *terrain-cure*. There are many good hotels; notably *The Schwarzwald Hotel*, from whose proprietor (Mr. Luz), or from Mr. Hortranft, Stadt-Schul-Haus, Freudenstadt, all particulars can be freely obtained.

Wild-Bad.—This other Wurttemberg Spa must not be overlooked when writing about the Black Forest. Located on the northern limit of the Forest, 1,500 feet above ocean-level, amidst romantic and rugged scenery, and with a climate adapted for a comfortable residence, from early April to late October, Wild-Bad possesses Mineral Springs of great value in treatment for chronic complaints of the bones, joints, scrofula, metallic poisonings, lameness, cramps, neuralgia, nervousness, gout, &c. It has fine fishing and shooting, tennis and croquet grounds, theatre, library, conversation rooms; and good hotels, as Klumpps, Russie, Concordia, Bellevue, Belvedere, and Blumenthal Pension.

Operating Theatres.

ROYAL FREE HOSPITAL.

Operation for Rupture of the Urinary Bladder.—Mr. T. P. Legg operated on a man, æt. 28, who had been kicked in the abdomen about eighteeen hours previously. When admitted, the patient was under the influence of alcohol, and the only history obtainable was that he had been kicked. There was no bruise or other sign of injury to the abdominal parietes. The abdomen was a little distended, moved freely with respiration, and on percussion an impaired note was found in the right iliac fossa. The liver dulness was absent. The patient complained of pain coming on in paroxysms in the epigastric and umbilical regions; his pulse was small and 96 per minute. These were all his symptoms, except a great restlessness. It was evident from the symptoms that some grave abdominal lesion had been sustained, and immediate operation was decided upon. A catheter was passed into the bladder, and a quantity of blood-stained urine was drawn off in a slow stream; this at once suggested that the bladder had been ruptured. An incision in the middle line of the abdomen with the umbilicus corresponding to its centre was made, and the peritoneum having been divided, a large quantity (between three and four pints) of urine and blood escaped. On passing the hand into the peritoneal cavity downwards towards the bladder region the laceration in the wall of this viscus was easily felt on the posterior aspect. The incision was now prolonged downwards and just above the symphysis pubis, the intestines were allowed to escape partially from the wound, and the peritoneal cavity was flushed out with a large quantity of sterilised saline solution, the escaped intestines being wrapped up in warm towels. When the abdominal cavity had thus been completely washed free of the urine, the patient was put in the Trendelenburg position; the bladder was then easily drawn up to the parietal incision; the laceration was found to be entirely intraperitoneal, horizontal in direction, and two inches in length, the edges being regular and infiltrated with blood. It was closed by two layers of continuous catgut sutures. the first and internal layer was passed through the muscular coat and the deeper part of the mucous membrane in such a way that the inner surface of the mucous membrane was not penetrated; the outer row of stitches was passed through the serous and muscular coats of the bladder. A drainage tube was placed in Douglas's pouch and brought out through the lower angle of the abdominal incision. A No. 10 catheter was tied into the bladder. Mr. Legg remarked that rupture of the bladder was not a very common accident, but for this very reason, and because it usually occurred in patients in a condition similar to this one, as a result of such an injury as a kick or a violent blow, it must always be borne in mind by the medical attendant, and a catheter should always therefore be passed at the earliest possible opportunity In another class of cases, the rupture of the bladder, he pointed out, was a complication of fracture of the pelvis, and in all these cases a catheter should be passed. The diagnosis, he considered, was not always easy, even when a catheter had been passed; blood-stained urine being withdrawn suggested injury to the bladder or damage to the kidney. If the rupture of the bladder was intra-peritoneal, a good deal of help in the diagnosis might be obtained, he thought, by putting in through a catheter, a known quantity of sterilised salt solution or boracic lotion, and then measuring the quantity which can be withdrawn, whether it was greater than that put in, if it were blood-stained, and the force with which it returned; if the amount was considerably increased this means that urine is also coming back with the solution; if the bladder were intact the stream would be full and forcible. When a rupture was present the stream is slow, and varies with respiratory movements. Absence of evidence of injury to the abdominal parietes he deemed of no value in helping one to diagnose the presence or otherwise of intra-abdominal injuries; this particular case, he pointed out, was a good example of most serious damage being sustained with no external signs of injury. The character of the urine had, he pointed out, an important bearing on the prognosis; if the urine is healthy, peritonitis is late in coming on; when the urine is foul and septic the reverse holds good, and the prognosis is correspondingly bad. When the operation is done the peritoneal cavity must, he insisted, be thoroughly flushed out, and all urine got rid of at once, and to do this effectually it was necessary to allow the intestines to escape at least in part through the long parietal incision. In closing the rent in the bladder, he pointed out, stitches should not penetrate into the lumen of the bladder, and should be preferably of catgut, which is readily absorbable. A continuous suture was more quickly inserted than interrupted ones and was equally efficacious. With reference to tying in a catheter, Mr. Legg thought that this was perhaps safer, as it prevented urine accumulating in the bladder, and therefore there was less risk of the latter becoming over-distended and leakage occurring through the wound into the peritoneal cavity; it would be safe to remove the catheter about the third or fourth day, and subsequently, to pass it every four hours. The alternative method was to pass the catheter at regular intervals of four to six hours, thus preventing any over-distension of the bladder. It is advisable he considered to put a drainage tube into Douglas's pouch for the first day or two in order to prevent any accumulation in that locality. For the successful treatment of ruptured bladder early operation he considered was essential. Excluding septic peritonitis, the main cause of death, he said, was shock and collapse, which in these cases was generally very great.

Unfortunately the patient collapsed and died a few hours after the operation was completed.

ST. PETER'S HOSPITAL FOR STONE.

Suprapubic Lithotomy.—Mr. Swinford Edwards operated on a man, æt. 63, who had been admitted with obscure symptoms of stone in the bladder. The patient had been sounded several times with different results; on the last occasion the surgeon thought he detected a calculus. Cystoscopy was performed at St. Peter's, but a good view of the interior of the bladder was not obtained owing to some prostatic hæmorrhage. As but little could be learnt in this way, the bladder was emptied by means of a catheter, and with two fingers in the rectum and simultaneous deep pressure being made suprapubically, Mr. Edwards was able to detect what he believed to be a large calculus. He elected to do a suprapubic lithotomy forthwith without first trying litholapaxy. Therefore, the bladder was distended with about sixteen ounces of hot boracic solution and the usual suprapubic incision made in the mesial line. On exposing the anterior bladder wall the injection of more fluid did not seem to make much difference in the distension of that part of the bladder which felt quite hard. An incision was made through the bladder wall, and this immediately cut on to a rough calculus which was tightly grasped by the surrounding bladder wall. An incision of two and a half inches in length was required to extract an unusually large spiculated oxalate of lime calculus of the size of a golf-ball. When the bladder wall was incised, there was no escape of the fluid in the viscus, nor did this find its way out until the stone had been extracted, a proceeding in which there was some difficulty, owing to the sharp spiculæ on the stone and the tightness with which it was grasped by the bladder wall. On the extraction of the stone there was a copious rush of the fluid with which the bladder had been distended, and the finger passed through an opening in the bladder proper. Mr. Edwards estimated the opening between the sac and the bladder to be about the size of a new florin. The bladder was found to be quite clear of all calculous formation. The opening between the sac and the bladder was now dilated by means of the fingers, and after the insertion of a *coude* catheter per urethram the incision into the bladder wall (or wall of the sac) was closed with cutgut sutures. The rectus abdominis was also sutured and lastly, the integuments, only a small gauze drain being left in. Mr. Edwards remarked that this was not an instance of an ordinary sacculus communicating with the bladder, for these sacculi are usually found to have no muscular coat, being generally formed of herniated mucous membrane, a layer of fibrous tissue and peritoneum when in that portion of the bladder which is covered by this membrane. In this case the wall of the sac was as thick as the wall of the bladder proper, and Mr. Edwards was inclined to regard it rather as a specimen of hour-glass contraction of the bladder, the upper chamber of the hour-glass contraction being entirely occupied by the stone. The stone itself was a beautiful specimen of a mulberry calculus, and was quite the largest and most regularly spiculated Mr. Edwards had ever seen.

The patient made an uninterrupted recovery.

Mortality from Plague.

The vital statistics relating to the Punjaub for 1904 show a lamentable mortality from plague, which alone accounts for a death rate of nineteen per thousand, and the total death-rate for the provinces reached forty-six per thousand. It is not generally recognised, writes the India Correspondent of the *Lancet*, that plague carries off the flower of the population and not the very young or the aged. The infantile mortality has been affected hardly at all. The Sanitary Commissioner estimates that the population has been reduced by nearly 1½ per cent. since the census of 1901.

The Sanitary Inspectors' Autumn Conference, held at Carpenters' Hall, London, has been largely attended under the presidency of Sir J. Crichton-Browne.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 30, 1905.

MEDICAL ASPECTS OF THE AGAPEMONE.

The medical profession is clearly concerned with the various bodily and mental actions of mankind, both in their healthy and their diseased manifestations. Of all the mental disturbances it is called upon to investigate there can be few more important than that of sexual aberration. The necessity of an exact scientific study of that complex region of psychology is now widely recognised, but nevertheless it may be pretty safely asserted that while the labourers therein are few and far between, the field to be explored is still of the widest. When, however, lack of sexual morality is coupled with mental delusions, the diagnosis is to that extent rendered easier, for in that case the erotic mainfestations are in all probability concurrent symptoms of insanity. Keeping these points in view, it will be interesting to discuss briefly some of the issues raised by the doings of a so-called religious sect that has recently been brought prominently before the public. Some years ago a Church of England clergyman, seceding from a previously formed sect, announced that he was the Christ and was gifted with all the attributes of the Almighty. Although originally a poor man, he has managed to bring a large amount of wealth to his peculiar community from wealthy persons who have been induced to join the sect. A large property has been bought at Spaxton, Somersetshire, where a number of persons live in strict seclusion in a luxurious retreat known as the Agapemone. The leader of this body, the Rev. J. Smyth-Piggott, a married man, has recently registered the illegitimate child of which he is admittedly the father. The mother is one of a number of young women who reside in the Spaxton abode. From published interviews it appears that some of the inmates, at any rate, are firmly persuaded that both Piggott and the infant are divine personages. From the medical point of view this brief history reads like a remarkably clear account of delusional insanity, accompanied by sexual manifestations, especially if we take into consideration the reports which persistently attach sexual immorality to all stages of the origin and progress of Piggott's mission. At the same time, it is only fair to assume that some of his disciples are sincere in their emotional surrender, and are free from any sexual taint. The question now arises, how is this matter to be dealt with in the best interests of the community? If this man be mentally irresponsible there should be some means of staying the terrible harm he is causing to the weak-minded persons who believe in his insane delusions, and whose property he is said to have acquired. If, on the other hand, he simply calls himself the Messiah in order to secure the bodies and the goods of his dupes, then he should be amenable to the criminal law. There appears to be no way out of that dilemma. Either Piggott is mad or not mad. In the one case he should be brought under the control of the Commissioners in Lunacy, in the other he should be tried for conspiring to defraud. That a man should be permitted under any conceivable set of circumstances, whether he be knave or madman, to go on working havoc among the weaker members of the community is a supposition that cannot be for a moment tolerated. Some means must be found by intervention of Government, if necessary, to put a stop to the scandal. At first sight it would seem an easy matter to put the lunacy law into action against a person who publicly and repeatedly asserts himself to be Christ returned to earth. A similar assertion is to be heard a hundred times daily within the walls of our lunatic asylums. Should a formal official investigation fail to demonstrate sufficient grounds for declaring Piggott to be insane, the police by that time will in all likelihood have gathered sufficient facts to warrant their interference. Of this we feel assured, that to permit a body of persons to seclude themselves in a kind of private fortress, while their published utterances are of a kind to warrant a *primâ facie* suspicion of insanity, is to incur a public danger of a grave nature. The subject, however unsavoury, should be dealt with promptly and thoroughly on medico-legal grounds that we have considered it our duty as a scientific journal to indicate.

HOSPITAL ISOLATION IN SCARLET FEVER.

Last summer a series of articles questioning the value of hospital isolation in scarlet fever appeared in The Medical Press and Circular, and we were so far moved by the facts and arguments brought forward by our contributors as to express a strong opinion that a public inquiry into the whole subject was called for. Naturally our contributors approached the question from different standpoints, and each expressed views that were not received *in toto* by the others; but they were unanimous in the opinion that the extensive provision of isolation hospitals for the treatment of scarlet fever had not resulted in any definite fall in the incidence of the disease, and, seeing that the system had been in operation for a considerable number of years, they considered that the apparent failure of these hospitals to fulfil their primary function, namely, that of disease prevention, called for careful inquiry into the factors at work. Beyond all reasonable doubt such a case was made out. It is interesting to observe that though no official inquiry has been instituted, the demand for it not only has not abated, but, on the contrary, has grown in force, and that many medical officers of health who till recently were of the "orthodox" faith, have come to regard the utility of these hospitals as questionable. In fact, the isolation hospital as an article in the sanitary creed has had so many doubtful adherents, that it is quite permissible for such doubts to be openly expressed without their author being shouted down as a fool or a knave. That, at least, is an advance, and pending an inquiry which must come sooner or later, it is well that the points at issue should not be lost sight of. Most of these found expression in the discussion on the value of hospital isolation that took place in the State Medicine section of the annual meeting of the British Medical Association at the end of last month. This discussion was opened by Dr. George Wilson, Medical Officer of Health for Mid-Warwick, a hygienist of wide experience in rural sanitation. From an exhaustive examination of the returns in his own area he stated he had elucidated the striking fact that those districts which were without hospital accommodation actually sustained a lower incidence-rate from scarlet fever than those districts with hospitals. Moreover, as the case-mortality showed no appreciable difference in either, it was difficult to contend that the great expense entailed by the up-keep of the hospitals had proved of any particular advantage to the districts that had provided themselves with hospital accommodation. On further analysis of the figures, he had found that more than half the cases occurring in non-hospital districts were single ones, and in hospital districts when the patients had to be retained at home owing to the hospitals being full, the same phenomenon was noted. Dr. Wilson contended that as a preventive measure against scarlet fever, the hospitals were practically valueless as they neither reduced the incidence nor the fatality of the disease, and a far more economical plan would be for the authorities of rural districts to have power to provide nursing for scarlet fever patients, together with compensation to breadwinners who were debarred from following their employment owing to the presence of infectious disease in their homes. Following on the same side came Dr. Whiteside Hime, Dr. J. E. O'Connor, and Dr. F. H. Waddy, the last-named presenting conclusions derived from perhaps the most complete inquiry that has yet been made in any single town. A number of medical officers of sanitary authorities, including Dr. Boobbyer, President of the section, combated the arguments advanced, but in the end a motion in favour of asking the Local Government Board to institute an inquiry into the value of isolation in scarlet fever and diphtheria, was carried by the section. This resolution, following as it does on a similar one carried in the Preventive Medicine Section of the Congress of the Royal Institute of Public Health last year, and others of a like nature passed at various other gatherings, during the intervening twelve months, is significant of the change of mind that is taking place on the subject. In his annual report for 1904, Dr. J. C. Eames, Medical Officer of Health in the Kearsley Urban District, writes: "Hospital treatment (for scarlet fever) has proved quite incapable of stamping out the disease, and it is an open question as to whether it even diminished the number." Dr. Martin, Medical Officer to the Gorton Urban District Council, in his annual reports for 1903 and 1904, writes in a similar strain, and, indeed, as long ago as 1895 he expressed the opinion that scarlet fever could, with certain precautions, be treated at home with but little fear of spreading. The opinions of medical officers of large towns like Portsmouth and Leicester are of a like trend, and are well known to our readers. Nor have their views failed to reach members of sanitary committees and town councillors all over the country, many of whom are actively interesting themselves in a question that involves the expenditure of so large an amount of the ratepayers' money. It would be premature at present to say that there is no value in hospital isolation as a preventive measure, and the convenience that these institutions afford to medical officers of health and to poor patients is obvious; but it is plain that hospital isolation has failed to make any deep impress on the incidence of scarlet fever, and that it is attended by many undesirable features. "Return" cases are frequent and cause much annoyance to medical officers and the public, and the number of cases sent into hospital under erroneous diagnoses has attracted invidious comment. Both of these drawbacks appear to be inevitable accompaniments of the hospital system, while medical knowledge of scarlet fever is as little exact as it is at present. By such an inquiry as is proposed, the credit of the profession in regard to these reproaches would be re-established, and nothing but good would result if it were shown how by some modification of the present plan, isolation could either be made effective, or limited to those cases that are attended with special danger to the public, such, for instance, as occur in laundries and dairies. We hope that the matter will not be allowed to rest where it is.

NEW ORLEANS EPIDEMIC OF YELLOW FEVER.

The departure of the eminent experts, Professor Boyce and Major Ronald Ross, for the suffering city of New Orleans forms, we trust, an abiding landmark in the history of preventive medicine. At present the perusal of the columns of the daily newspapers of that city resembles a good deal that of an historical romance. The "yellow jack" has appeared, without official invitation, in its midst; and although not quite so murderous in its progress as in some former visitations, it has aroused the municipality and citizens to an activity which may be characterised as heroic, and the result is that New Orleans is having such a washing, brushing, and scraping—and all-round cleansing—as it has never received since the day of its original baptism. The physical environments of the city are decidedly unfavourable. It lies 18 feet below the surface level of the "Father of Waters," from which it has to be continuously fenced off by its famous "levee." The result is that drainage can be carried out only by a pumping arrangement, and the erection of covered drains is now in progress throughout the city. Then the chaos of swamps which surround the city forms a colossal difficulty, as they have hitherto represented an ideal paradise planned and watered for mosquito residence and revellings. And the absolution by flat streets of the city form another engineering obstruction. But on this occasion the collective citizenship of New Orleans seems to have sprung to its feet for combined and heroic effort against the invasion of the common foe. In addition to the employment of a vast army of street cleaners of the regulation type, thousands of volunteers are working hard day after day—visiting houses seriatim, discussing with the residents the most appropriate methods for purification of standing water, teaching the value of oiled cisterns, and impressing upon the careless and the fatalistic the incalculable importance of the use of the mosquito net. All public uncleanness is pointed out and dealt with, and all sanitary offences are brought under the notice of the Board of Health. It is not a matter now of every resident fulfilling to the letter every sanitary commandment with regard to his own dwelling, and the corresponding half-breadth of street before the same; every active citizen of New Orleans has become a member of the sanitary host which is fighting the deadly invader in every part of his city and its surroundings. "Successful" and "dignified" merchants and financiers are acting as volunteer superintendent scavengers, and some have even given manual assistance in every detail of the work. From pulpits of all denominations flows Sunday after Sunday a torrent of the most inspiring eloquence, asking all true citizens to give time and money to the common cause. Public meetings are held daily for the purpose of evoking enthusiasm in the sanitary campaign, and at every one the eloquence of the speakers is rewarded by the enlistment of numbers of volunteers who offer their assistance in the most unpleasant details of the sanitary engineering. Ditches are already conveying water to the canal from quarters where it had previously been stagnant and furnishing luxurious conditions for mosquito life. The whole face of New Orleans is said to have been transformed within a few weeks. And the highest testimony to the discipline and public spirit of that city is furnished by the fact that in no single instance have the volunteers come into collision with the professional members of the Public Health organisation. Under such circumstances, while we condole with the citizens of the great western community in their calamity, we cordially congratulate them on the public spirit and patriotic self-denial which have been brought into so conspicuous prominence by its occurrence.

Notes on Current Topics.

The Danger of the Sleeping Cars.

We have the very highest authority for the validity of the statement that the increase of knowledge carries with it the increase of sorrow; we are assured by moralists—and the assurance is corroborated by the universal experience of ages and nations and individuals—that every vicious gratification of sensual proclivities is sure to be followed by penitential consequences, and our dispassionate and mechanical twentieth century seems to be continuously discovering that every increase of physical comfort, and development of (apparently innocent) luxury is bound to convey its shadowy surface of tainting influence with it in its progress. The bathos of such discouraging revelation would almost seem to have been sounded by Dr. A. W. Wiley in a recent address to Columbia University on "The Physician of the Future." "It is difficult to imagine any contrivance which human ingenuity could construct better calculated to secure the best conditions for disease and the best methods for the propagation thereof than the sleeping car." The lecturer indicated the principal physical reasons for the faith which existed within him on that interesting subject. He pointed out that the vehicle in question is constructed in such a way that ventilation is practically impossible; how it is partitioned into small compartments—carefully curtained so as to prevent any circulation of fresh air, if any fresh air happen to be within reach; provided with enough heating surface to the cubic yard to complete the installation of a Turkish bath; manned by porters to whom a high temperature is an evidence of heavenly bliss; and, accordingly, represents an ideal hot-bed for the growth and culture of germs, as well as entailing obvious physical drawbacks which require no microscope to see and no æsthesiometric tests to confirm. Some little time ago a railway company announced with (what professed to be) honest pride that the blankets of its sleeping cars were always washed at least twice a year! And these compartments may often carry, without any precautionary inspection, persons in all stages of phthisis, and even other contagious diseases. "There is no health officer to inspect incoming passengers, no provision of the law requiring complete fumigation, and no systematic appliance of any kind to prevent or eradicate disease." Of course, there is nothing of all this; and we cordially thank Dr. Wiley in the name and interest of a long-suffering and much-abused public for pointing out so forcibly the existence of such a glaring want. We will further express the hope that Dr. Wiley's pronouncements may ultimately have the same effect on the twentieth-century sleeping-car that John Howard's had on the eighteenth-century gaol. Having regard to lapse of time and growth of knowledge—and of sensory nerves, one consummation is now to be as devoutly wished as was the other then.

Metropolitan Asylums Board Report.

The annual report of the Metropolitan Asylums Board grows in bulk and in interest every year, the duties of the Board having now expanded to such an extent as to include the administration of seventeen hospitals, five asylums for imbeciles, fifteen schools for children suffering from ringworm, ophthalmia, and similar complaints, eight ambulance centres, and a training ship. No less than 21,721 patients passed through the fever and small-pox hospitals during 1904, 21,183 of these patients suffering from fever or diphtheria, and 538 from small-pox. The mortality rate, except in the case of enteric fever, was slightly higher all round than in 1903, but the difference was fractional only, and it is significant of the mild type of scarlet fever that has prevailed of late years that the case-mortality only stood at 3·37 per cent. in 1904, and 3·10 per cent. in 1903. The diphtheria mortality-rate maintains the very satisfactory level that it has stood at for the last few years. In 1904 it was 10·08 per cent., only some 0·4 per cent. higher than in the preceding year a benefit largely attributable to the free use of antitoxin. It must be remembered, however, that the term diphtheria is used in a much wider sense now than it was ten years ago when antitoxin was introduced, and that a large proportion of the cases are only "bacteriological" diphtheria. The value of antitoxin is proved—if any further proof were needed—by the interesting figures given showing the results of treatment in different days of disease, the mortality rising consistently with time that elapses between the patient being taken ill and antitoxin being administered. There was a distinct increase in the number of days of detention of patients in hospital as compared with the previous year in each disease except small-pox, and it is noticeable that scarlet fever patients are kept longer than any others. The period of treatment of this disease has stretched from the traditional six weeks to no less than nine, a fact that has an important bearing on the cost of isolating the disease.

Breast v. Hand Feeding.

Every mother and every nurse has her own theory of how a child should be fed. This one prefers milk; that one a particular brand of patent food; the other favours biscuits, bread, potatoes, or even worse things. The medical practitioner should have only one theory—namely, the breast. This natural organ of nutrition has yet to be replaced in the rearing of children, and it would be well for the fact to be brought home to every mother, or prospective mother. In his annual report on the health of Stockport, Dr. Meredith Young, the Medical Officer of Health, gives some remarkable figures that have come to hand in his department. During the past year, he has employed his two female inspectors in visiting every house in which a birth has occurred, and reporting on the progress of the child and its method of feeding. In all, 1,477 houses were visited, in 57 of which the child had died. Of the rest they found that of the 977 children fed by the breast, 957 (98 per cent.) were healthy, and only 20 (2 per cent.) were delicate. Of those partly breast and partly hand-fed—80 in all—57 (71·25 per cent.) were healthy, and 23 (28·75 per cent.) were delicate. Of the hand-fed children, a class including 363, only 115 (31·68 per cent.) were healthy, and no less than 248 (68·32 per cent.) were delicate. Of course, a certain number included in the last class may have been withdrawn from the breast because the mother was in bad health, or because the child did not thrive, but there is no denying the striking significance of the statistics Dr. Young presents.

Music as a Mental Stimulant and Anodyne.

The *Morning Post* has recently been concerning itself, and, we think, very judiciously, with the value of music in education. In its issue of July 29th, 1905, there is an account of a very interesting and suggestive interview with Mr. Cecil Sharp on the subject. It had previously contained an article on "The Teaching of Patriotism," in which the great value of music in cultivating the national spirit was forcibly emphasised. This is a fact which should require no argumentative details to support it. That was a keen observer of human nature who told his contemporaries—political and all others who might feel concerned—that if he were allowed to make the ballads of a nation he would allow anyone who liked make its laws. Let even his strongest political opponents and his bitterest personal enemies manufacture all the materials of the national code, he, the ballad-maker, would still remain king of the country! And the pre-scientific empiricism of the fighting nationalities sent their men into battle accompanied by the sound of horn, bagpipe, fife, and drum, &c. There is a sound physiological basis for such statements and practices, and explanation of their admittedly effective results. The effects on the circulation, in the case of all highly strung nervous systems, of the various kinds of music are so continuously under our notice that they have, like other familiar objects, almost ceased to be regarded as matter for critical discussion. Their existence —once striking—comes to be ignored, like the presence of the loud-ticking bedroom clock. The recommendation of music in medicine has been recently treated in medical journals of the strictly advanced type with a display of amused contempt. Yet its influence on the nervous system is undeniable; and has occasionally, in various ages of the world, received the most impressive testimony. Saul employed David to soothe his melancholy with the notes of his harp. Clinias, the famous disciple of Pythagoras, displayed one of the most characteristic traits of his philosophy by always flying to his harp whenever his temper became seriously disturbed. Pliny tells us that "Asclepiades, a noble physician, as oft as he had phrentick patients, or such as were unhinged, or evil affected in their minds, did make use of nothing so much for the cure of them, and restauration of their health, as symphony and great harmony and consent of voices." Also, that Ismenias, the Theban, "used to cure divers of the Bœotians of the sciatica, or hip-gout, by the use of musick." And we learn from Philostratus that when Apollonius asked Canus the Rhodian musician, what he could do with his instrument, he told him that he "could make a melancholy man merry, and him that was merry much merrier than he was before; a lover more enamoured, and a religious man more devout and more attentive to the worship of the gods." Such theory and practice retained at least a smouldering vitality down to the iconoclastic revolutions of modern science. It displayed a convulsive activity of scintillation in the treatment of the epidemic tarantulism of Southern Italy, after which it almost—if not quite—disappeared from view.

Paddington and the L.C.C.

An interesting situation has arisen between the Borough Council of Paddington and the London County Council. It appears that the Paddington authority for the execution of the Public Health Acts have after all these years failed to provide themselves with so essential a piece of sanitary equipment as a disinfector. This fact is in itself sufficiently astonishing, but it is even more so that, having given the contract for disinfection to a private firm, they should have allowed the process to be carried out in an unsuitable place and in an unsuitable manner. In a report made by Dr. Hamer to the County Council in 1902, it is stated that not only were the premises used for disinfection unsatisfactory, but that the vans conveying the infected articles were unloaded in a public street, and the articles themselves were carried across the foot-path to the firm's premises. The matter having been reported to the County Council, a letter was written to the Paddington Council, drawing attention to the facts, and asking for observations thereon. As the result some changes were made by the Paddington Council, and steps were taken to obtain the co-operation of the Kensington Council in the erection of a disinfecting station. But plan after plan failed, and after two years, no satisfactory arrangement having been made, the County Council have, after much correspondence, informed the Paddington Council that they have no alternative but to make a formal complaint to the Local Government

Board, under Section 101 of the Public Health (London) Act, asking the Board to make an order to have the work executed. In default of which the Board will have to enforce their order by a writ of mandamus or appoint the County Council to perform the duty. It is disgraceful to think that the Council of a rich West End borough of London can only be forced efficiently to carry out its obligations by compulsion, and that the authority responsible for the public health should be so little heedful of its own duty.

The Registrar-General's Weekly Return.

The weekly return of the Registrar-General for London and seventy-five other towns shows various points of interest. The highest death-rates per 1,000 living from all causes are those of Sunderland 23·2, Grimsby 23·7, Hull 23·8, Manchester 24·2, Henley 24·2, Wigan 25·9, Tynemouth 27·2, St. Helens 27·3. Deaths from diarrhœa reach 7·6 in Norwich, 7·7 in Sheffield, 9·7 in East Ham, 10·3 in Hull, 11·3 in West Ham, and 12·2 in Grimsby. It is interesting to note that not a single case of small-pox was registered in any of the seventy-six towns, a fact that may be commended to the consideration of the anti-vaccinationists. In London the average was 17·0 last week as against 14·3, 15·6, and 17·3 in the three preceding weeks. During the four weeks ended on Saturday, August 19th, the death-rate averaged 16·1 per 1,000, being 3·8 per 1,000 below the rural rate in the corresponding periods of the ten years 1895–1904. The deaths from diarrhœa, which had been 187, 314, and 372, in the preceding three weeks, rose to 395, and were 3·1 above the corrected average. Of these 395 deaths, 379 were those of children under five years of age: 33 deaths were in Stepney, 26 each in Hackney, Poplar, and Southwark; 25 in Lambeth, 24 in Islington, and 22 in Fulham, all of them, be it noted, poor and densely populated districts; 55 deaths were due to different forms of violence, and in all of them inquests were held.

Hygiene in Schools.

It is satisfactory to learn from the speech made by Lord Londonderry in opening the Congress of the Royal Institute of Public Health in London at the end of last month, that the Board of Education were duly impressed by the weight of the deputation of the medical profession that recently waited on the President to urge the teaching of hygiene and temperance in schools. That the seed sown by the deputation did not fall on stony ground is shown by the fact that the Board is about to issue a memorandum embodying suggestions as to how such teaching should be carried out, and we shall be interested to see the plan they propose. It is, as Lord Londonderry remarked, a comparatively easy matter to say that an hour a week is to be devoted to the teaching of hygiene, but it is quite another to insure that the hour will be well spent. It seems that the Board have been bombarded with suggestions from all sorts of well-meaning people, but that most of these have aimed at turning out pupils versed in all the subtleties of physiology and pathology. It is obvious that for a course to be of any value to elementary school children, it must deal almost entirely with the practical results of scientific knowledge and their applications to the circumstances of life, and it is comforting to know from his own lips that the President of the Board is fully alive to the dangers of abstruseness in such teaching. Surely, however, on the principle that who drives fat oxen must himself be fat, it is necessary to start with the instruction of the teachers who are to communicate knowledge to the children. Till all the masters and mistresses themselves are well grounded in hygienic principles, it is ludicrous to expect them to impart instruction to their charges. A good beginning might be made by using as a practical example the working of the schools themselves, a good many of which in many parts of the country can hardly be described as models of healthy construction and management.

All is Not Gold That Glitters.

There is little doubt that many consultants, both physicians and surgeons, not to mention specialists, live habitually beyond their means. They get appointed to the staff of a hospital and promptly embark on a house in Harley-street, and perhaps a carriage and pair. They have a butler and footman and entertain lavishly. They make a point of attending every social function to which they can obtain an invitation, and the public applauds their efforts. Their days and nights are thus taken up in frivolity. They contribute nothing to medical science or literature, and their hospital work deteriorates in quality. Their professional brethren cease to value their opinion and their consulting work falls off. The climax may be long postponed, but after a time there are rumours of financial embarrassment, the position becomes untenable and the scene ends abruptly. It is found that no provision has been made for the wife and children, and the hat goes round often without any tangible result. Those who have lived quietly and within their means are but little inclined to contribute their guineas and the inevitable has to be faced. It is a pity that such things should be, but the public attaches much importance to show, and too often medical flesh is weak enough to play up to their foibles in that particular direction.

An Undertaker's Gratitude.

Among the callings more or less intimately allied with the practice of medicine, that of the undertaker must regretfully be included. In spite of a good deal of sarcasm to the contrary, it is after all true that the doctor's business in life is to rob the undertaker of his employment, just as the medical officer of health seeks to cut down the demand for the medical practitioner's services. As the world is at present constituted there does not appear to be any great likelihood of either doctors or undertakers being permanently out of employment, and in spite of a falling death-rate the undertaker's business can hardly be classed among Mr. Chamberlain's "decaying industries." One undertaker, at any rate, is flourishing, but with a degree of *sang froid* that presumably springs from enthusiasm for his vocation, he has lately forwarded £5 to one of the Bishop of London's funds as a thank-offering, "because trade is good just now." We presume that most people would not regard the circumstances leading to this gift as a subject for any particular thankfulness, but every man is entitled to his own opinions, and the contributors to the undertaker's prosperity would probably prefer that the surplus should go to the Bishop's funds than to the furnishing of a wake, or whatever is the usual form of jubilation among undertakers. We reflect sadly that we did not hear of any bounteous donations to charitable funds from the public vaccinators during the late epidemic of small-pox in London.

False Charge Against a Chemist.

From a case tried in a West London police court last week, it is evident that chemists have unfounded charges brought against them just as happens now and then with medical men. The charge was one of maliciously administering chloroform to a young woman of no occupation, with intent to commit some indictable offence, "or so as to endanger her life, or to inflict on her grievous bodily harm." The prosecutrix stated that she felt faint and went into the shop of accused, and asked for sal volatile. She took the draught given her, and after that remembered nothing until she found herself lying on a sofa upstairs. On leaving the shop later with her sister she was seized with a hysterical fit. Defendant stated he had given her a draught of sal volatile with chloroform water. It is possible that the faint smell of the minute quantity of chloroform in this mixture may have suggested the idea of drugging to a young hysterical woman. We are glad to say the case was dismissed by the magistrate with the remark that there was nothing in the evidence to suggest that any impropriety was offered to the lady. At the same time it would be wise for any chemist under similar circumstances not to take patients into private rooms.

The Medical Examination of Volunteers.

The present Government appear to be bent on a deliberate policy of exasperation, so far as the volunteers are concerned. The obnoxious order of Mr. Arnold Forster for the medical examination of volunteers as to fitness for foreign service has been partly enforced by Mr. Arnold Forster taking a mean advantage of the disciplinary powers of commanding officers over volunteers in camp. Our vigilant contemporary, *Truth*, calls attention to an incident in this connection which we would fain hope for the credit of the War Office is capable of satisfactory explanation. The statement is that the Welsh Border Volunteer Brigade was persuaded with some difficulty to go through the obnoxious examination. Then came a special medical delegate from the War Office to examine the recruits. These men, it is said, were paraded "in the most public part of the camp, stripped in the most indecent way, and medically examined before the eyes of a large number of curious spectators of both sexes, and amid the jeers of a portion of the crowd." Mr. Arnold Forster seems bent on the extermination of the Volunteer force. He seems curiously blind to the political unwisdom of rousing the opposition of so large and important a body as that branch of the auxiliary forces.

Dr. Doyen's Proposed London Cancer Home.

The public newspapers during the last few weeks have contained almost daily references to the intention of Dr. Doyen to found a home for the treatment of cancer in London. In a matter of this kind we feel it to be the duty of a medical journal to express clearly the attitude likely to be taken up by the profession with regard to this proposed step. Of special homes and special treatment for cancer there are already far too many in the United Kingdom. No cure for that terrible malady is yet known to medical science, except in some recent surface forms which are curable by certain modern methods. But cancer in its ordinary sense is incurable, although prompt and thorough removal at an early stage by the surgeon's knife may prolong life for many years or even indefinitely. Why should Dr. Doyen add to the discredited treatments with which our countrymen are already overrun? A medical tribunal of the highest and most irreproachable nature has inquired into his "system" and found it wanting. Why should he try to introduce his treatment on a commercial basis into England? The only alternative, so far as we can see, to commercial enterprise is sheer and unadulterated obstinacy. It is impossible, however, for scientific men to doubt the accuracy of the sweeping condemnation of the Doyen methods pronounced deliberately by the Paris Academy of Medicine. There is no professional jealousy in the question—witness the untiring efforts of our scientists on this side of the Channel to disclose the baffling secrets of this disease. If Dr. Doyen comes here at all let him come as a philanthropist and give his treatment gratis to all alike, free of suspicion of commercial taint.

Oysters and Typhoid Fever.

The oyster has recently been receiving from the sanitarian and the bacteriologist an amount of scientific attention which is probably unprecedented, even in the peculiar experience of the luscious bivalve. Dr. Klein's researches, which were undertaken on behalf of the Fishmongers' Company, went to show that while the influence of the oyster pollution on the general prevalence of typhoid fever had been probably a good deal exaggerated by popular opinion, the effect was nevertheless one of material dimensions, and sufficiently important to call for further study of the means of prevention. A French Commission, under the directing control of Professor Girard, has recently been examining the question, and his report—markedly cautious and conservative as it is—is drawn up on corresponding lines. He has no doubt that typhoid fever may be transmitted by polluted oysters, while he still believes that some of the cases cited in testimony of the fact are based on questionable evidence. He points out, emphatically, that the bacterial diseases of the oyster are not transmitted to man. The United States investigations confirm these conclusions. Dr. G. W. Fuller, of the Franklin Institute, declares that: "Those who do not recognise any relation between the pollution of shell fish and the causation of disease have either not looked into the matter or have biassed views for commercial reasons." A remarkable feature of the United States census reports is that the death-rate attributed to typhoid fever is nearly double the average normal among men collectively grouped as "sailors, pilots, fishermen, and oystermen." It has, of course, been suggested that oyster-beds might be purified of germ contamination by treatment with copper sulphate—a bactericide whose valuable qualities have recently been rewarded by special notoriety. From the results of the investigations carried out by our own War Office, it would, however, appear that the anti-microbic powers of $CuSO_4$ have been over-magnified; a solution 1 in 10,000 being the weakest which can destroy the typhoid germ. That proportion would prove in itself dangerous in continued use. And what gourmand could ever be induced to take his naturally most palatable tit-bit freshly dripping from a solution of emetic "blue-stone"?

PERSONAL.

We understand that Dr. Jameson, the Cape Premier, who is at Carlsbad, has now completely recovered from his recent indisposition.

On the first Thursday in October, the Secretary of State for War will lay the foundation stone of the new cavalry barracks to be erected at Norwich at a cost of some £200,000. When, on account of sanitary deficiencies, the existing barracks were condemned a representative committee of the leading citizens purchased twenty acres of ground as a site for new military headquarters.

The York Corporation Health Committee, acting upon the advice of Dr. E. M. Smith, their Medical Officer of Health, are asking the Education Committee to discourage the attendance of children under five years of age at the elementary schools in the city.

On August 24th Colonel Bruce delivered a lecture in the City Hall, Durban, on "Sleeping Sickness," illustrated with lantern slides. The lecture was preceded by a civic reception by the Mayor and Council of the city.

Dr. W. H. Best, medical officer of Lagos, has arrived in England on leave of absence.

Mme. Dantchakoff, of Ekaterinoslaw, who was the only lady who took an active part in the recent International Anatomical Congress, presented a report on the functions of the plasmatic cells in the glands of the lower jaw of the rabbit. Dr. Christini gave a very interesting lecture on imbecility, its treatment and cure, and Dr. Barfurt, of Rostock, read his experiments in the regeneration of the peripheric nerves. Michel Sevret, whose tomb was decorated by the International Anatomical Congress, was born in 1511. He was a learned doctor, and followed Karl V. to Germany. In 1531 he published at Hazenau "De Trinitatis Erroribus," which caused a great deal of excitement in the clerical world. He was imprisoned for this, but subsequently released. He went to Paris in 1537, when he made a close study of the circulation of the blood, and in 1540 to Vienna, and there published, in 1553, "Christianismi Restitutio," in which he rejected the doctrine of the Holy Trinity as being fundamentally incorrect. He was imprisoned at Geneva at the request of Calvin as a madman and burnt to death.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

BELFAST.

Maternity Nursing in Derry.—At the last meeting of the Derry Guardians the question of maternity nursing was under discussion, and some interesting facts came out. Drs. Craig and Cunningham had asked for two additional nurses in their district, and Dr. McCarthy, the Local Government Board inspector reported that there was only one midwife for the two city dispensary districts, and she was over seventy years of age. She had attended 253 cases during the past year. The guardians agreed to appoint one additional nurse, but gave a solemn warning to the doctors that they must not for a moment imagine that they could throw over their responsibilities on the midwives and curtail their own work.

Sanitary Condition of Lisburn.—Thanks in part to the recent outbreak of small-pox in Ulster, some attention is being paid to the sanitary condition of the smaller towns, where great laxity has prevailed. The Lisburn Rural Council has received the report of the Local Government Board inspector on their town, and it cannot be called flattering. It appears that there is no systematic inspection of the meat and milk supplies. Two years ago the water supply was reported as insufficient, and nothing has yet been done to increase it. The sewerage in some parts is most defective, the common lodging-houses are not inspected, there is no disinfecting apparatus, and the Infectious Diseases Act has not been adopted.

Correspondence.

THE CANCER PROBLEM.

To the Editor of the Medical Press and Circular.

Sir,—You did me the honour to insert in the *Medical Press and Circular* of July 26th a suggestion and hypothesis bearing on the prevention of the evolution of cancer.

I will not now repeat the general argument on which the hypothesis was based, but simply give an illustration of the biological method.

A graft, say, of a large, sweet, well-flavoured apple, is grafted on the hardy trunk of a crab-apple tree. The result is that the future tree which grows from the little sprig has the character and qualities of the finer tree from which the sprig was cut. This difference of quality, during the future life of the tree, affects and modifies all the tissues; the chemistry of the bioplasm, the rate of growth, &c., are all affected.

Darwin's magnificent, "Provisional Hypothesis Pangenesis" is now, as far as these "gemmules" are involved, discarded; we now, in place of the "gemmules," view the ultimate modes or motions of "matter" as orderly systems of revolving "electrosis."

But whether through "gemmules" or "electrosis" the little twig of grafted apple stem has imparted a mode, or "motion," or energy to the whole future tree—has modified its growth even to the profounder energies and powers of the seed.

Might we not modify and divert the evolutionary energies of growth which, at the cessation of the menstrual period, find their expression in an exuberance of epithelial, &c., growth—cancer?

Virchow taught us that "every diseased structure has a physiological prototype."

In view of these facts and analogies, would it not be a justifiable experiment to graft into the skin of women who are developing, and passing on to cancer cells, the ovary, say, of a sheep? Might it not restore the balance of the evolutionary energies? Might it not to some degree restore the balance of that cell metabolism which obtained in the pre-cancer periods, prior to the cessation of the great universal monthly functions?

My suggestion is but an approximative hypothesis. I crave the shelter of Herschel, who says (Prel. Dis., par. 208), "Now, are we to be deterred from framing hypotheses and constructing theories because we meet with . . . dilemmas, and find ourselves frequently beyond our depth? Undoubtedly not." "A well-imagined hypothesis, if it have been suggested by a fair inductive consideration of general laws, can hardly fail at least of enabling us to generalise a step further, and group together several such laws under a more univeral expression."

Yours truly,

Plymouth. **William H. Pearse.**

AN ANTI-VACCINATION ARGUMENT.

To the Editor of the Medical Press and Circular.

Sir,—"Fas est ab hoste doceri" was a quotation familiar to most of us "in the days of our youth," and it is sound in the days of our "age." I enclose you a cutting from the *Belfast News Letter* of yesterday of a letter from Mr. Horace Mansell, of St. Michael Street, Tipperary, with which I thoroughly concur as to the reasonable conclusion, why should re-vaccination not be made compulsory in the Land of Services, as it is in Germany and other places *all round*, and not merely for those serving in the Army and Navy and Civil Service? The only reply can be that the Government are afraid of acting on their convictions and protecting the general community as they should.

I am, sir, yours truly,

J. Wybrants Olpherts.

P.S.—It seems in the public services the employees' "consciences" are of little account.—J.W.O.

Downpatrick, August 26th, 1905.

The letter which our correspondent encloses is as follows:—

"Sir,—I noticed in your issue of the 19th that a Mr. Melville was prosecuted as a vaccination defaulter and fined 20s. and 12s. 6d. costs. Now, I do not propose to enter into an argument as to the merits or demerits of vaccination, but I would like to point out to your readers the fact that doctors are unanimously of the opinion that the protection—such as it is—afforded by vaccination, wears off in a few years, ten at the most. This means that in Belfast there are well over 250,000 people who are just as unprotected (the effects having worn off) as Mr. Melville's unvaccinated child. Yet all these 250,000 "dangers to the community" go about unmolested, while Mr. Melville is prosecuted and fined. Surely a most absurd state of affairs.—Yours, &c.,

"Horace Mansell, Honorary Secretary, Irish "Anti-Vaccination League.
"St. Michael Street, Tipperary."

Obituary.

GEORGE FRANKLIN HILLIARD, L.R.C.P.S.Ed., L.F.P.S.Glasg.

We much regret to record the death of Dr. George Franklin Hilliard, of Bow Road, London, E., which sad event took place last week after a severe operation. Dr. Hilliard was born in 1858, and he was, therefore, only 47 years of age. He took the L.R.C.P. and S. Ed. in 1888, and was medical officer to the Mile End Scattered Homes. His genial and kindly figure will be much missed in Bow and Bromley. He leaves a widow and children to mourn his loss.

LEWIS CHARLES EDWARDS, M.B.Edin., OF COVENTRY.

The death took place last week at South Marine Terrace, Aberystwyth, of Dr. Lewis Charles Edwards, only surviving son of the late Rev. Principal T. C. Edwards. D.D. Deceased, who was thirty-four years of age, was educated at the University College, Aberystwyth, and at Edinburgh University, graduating at the latter place as Bachelor of Medicine in 1896. Five years ago he settled at Coventry, and had built up a successful practice as a medical man at that place. Failing health compelled him to relinquish it, and four months ago he came to Aberystwyth. He leaves a widow and three children.

PROF. HERMANN NOTHNAGEL.

Another of the most genial, honest, and philosophic professors of medicine has passed away from the Vienna School of Medicine on the 7th of July, in his 64th year. He suffered from stenocardia, and on the morning of the 6th had to take a cab to his lecture at the Clinic; unusual for him. He performed his task, but seemed weak and exhausted, which he attributed to the unusually long attack. The following day he died. He has a noble history of literature and good work to hand down to posterity, a summary of which would be too long to record here. Although his works cover every department in medicine, neurology was his special subject, in which he delighted to revel. He was an excellent teacher, enthusiastic, zealous and devoted to his work to the very last, and it may be said of him that he died in active service.

Literature.

GOULD ON WORDS. (a)

The vagaries of medical writers, and their exceeding ingenuity in the coining of new words, have rendered the production of this dictionary a matter of necessity, if "recent scientific literature" is to be understanded of the common folk. It is certainly well that, as the learned lexicographer quotes in the course of a most interesting preface, "dictionary makers" do not require souls, for assuredly if they did, and if they commenced their task with the possession of one, they would have lost it before they reached the end, and if by chance an unusually tough soul were to survive, it would be in such a mangled condition as to be valueless. Still, if the lexicographer needs no soul, surely he needs a conscience, which will prevent him from adding still further atrocities to an already long-suffering language. He must be without a soul to be able to deal with the word "dysmorphosteopalinklasy," but if he possessed a conscience he would not have added the word "laparosalpingooophorectomy," as he would not have stolen the hyphen which formerly saved it from disrepute, nor would "hepaticocholecystostcholecynstenterostomy" be attributed to a living author, while "oonoiodiddibismuthmethylenedicresotinate" would be intelligible to any chemist.

(a) A "Dictionary of New Medical Terms, including upwards of 38,000 words, and many useful tables, being a Supplement to An Illustrated Dictionary of Medicine, Biology, and Allied Sciences," based upon recent scientific literature, By George M. Gould, A.M. M.D., Pp. 571. London; Baillière, Tindall and Cox. 1905. Bound half morocco, price 21s.

However, such words only show the necessity for the appearance of this supplement, and the careful manner in which Dr. Gould has discharged his task. Words are intended to convey ideas, and if this old truism is perverted by the writers of recent "scientific literature" into a statement that ideas serve as the foundation for words, surely the lexicographer is not to be blamed.

ERRORS OF REFRACTION. (a)

THIS little book makes no pretension of treating the subject of refraction *ab initio*. It takes for granted a knowledge of geometrical and physiological optics, and in this we think the author is wise. Mr. Blair deals with all the errors of refraction in a very comprehensive spirit, with instruction, and without pedantry. The subject of squint, though in itself highly technical, is here made very plain and easy to follow. We specially commend the following advice, which quite embodies the most up-to-date opinion on the matter: "A squint not exceeding 15° needs a simple tenotomy of the internal rectus of the squinting eye, with suturing of the conjunctival wound afterwards. One of 20° requires a tenotomy with free division of the subconjunctival tissue. One of 30° a tenotomy of the internal rectus, with an advancement of the external. Lastly one of 35° or 40° needs a free tenotomy of the internal rectus, an advancement of the external rectus, and a tenotomy of the internal rectus of the good eye."

The subject-matter of the whole work is clear, concise, and to the point, and the book ought to prove of high value to the student and general practitioner.

ALCOHOLIC POISONING. (b)

THIS undated *brochure* is apparently an unauthorised translation of Professor von Bunge's "Alcohol vergiftung und Degeneration."

It is well that this remarkable monograph should be rendered available to English students, but we could have wished that it had been possible to have arranged for such editing as would have increased its value to English and American readers.

Professor Bunge with the assistance of over a hundred medical collaborators has obtained particulars regarding the health of more than 1,600 families. He has directed particular attention to the relation of alcoholism and nursing capacity. Carefully compiled statistical tables give the result of his analysis. His conclusions are certainly startling. Professor Bunge is a scientist of world-wide distinction, and he has devoted many years to a study of lactation and the various problems which circle the milk question, but before accepting his conclusions as applicable to this country we would like the matter to be submitted to further investigation. In order that we may faithfully present Professor Bunge's results we quote from this English translation of his work: "The daughter of a drinker is rarely, if ever, able to nurse her children. As a rule, where the father has been a drinker, the daughter loses the power to suckle her children, and the capacity is irrecoverably lost to all future generations. The incapability of nursing is no isolated phenomenon. It is accompanied by other symptoms of degeneration, in particular by a want of power to resist the inroads of disease of all kinds: nervous disorders, tuberculosis, decay of teeth. The children are insufficiently nourished, and so from generation to generation, the work of deterioration goes on, leading at length after endless suffering, to the ultimate decay of the race." This pamphlet is opportune in its appearance, and is full of suggestions, and will we trust do much to stimulate research in this country into the action of alcohol as an etiological factor in the production and transmission of morbid conditions.

SANITARY LAW AND PRACTICE. (a)

THIS is a most useful book; though primarily intended for the student, it is probably too ambitious for the average, and is likely to be of much more service to the medical officer of health who may want to be able to look up any point of law with reference to his work.

The fact that the various branches of the subject are treated in separate chapters, and all the relevant sections of various Acts of Parliament are collected, makes it of immense convenience and at the same time pleads powerfully for a codification of the innumerable existing sanitary acts.

The law for each division of the kingdom, where different, is given; consequently, at one time, one is reading English law, at another London or other law; it would be of great advantage to put a marginal note on each page to show to which division the page refers, and at the same time some indication to show where the law is absolute and where only adoptive.

The duties of the health official are well described, the chapters on unsound food and adulteration being particularly interesting, though it is not expedient to use the word "hydatid," for the cystic stage of tænia solium in the pig, but to reserve it for that of T. Echinococcus. The omissions do not seem to be many or serious; however, in the section on New Streets and Buildings there is no reference to the question of the height of buildings compared with the width of streets—a subject that certainly should not have been omitted. Again, the chapter on Prevention of Epidemic Diseases contains no reference to the Epidemic Diseases Prevention Act; it is true that the medical officer of health will find it of no importance to his work, but he would like to have this stated, or else he may be surprised to some day come across a reference to such an Act, which by its title suggests that it should concern him.

As regards the arrangement of the book there is little to be said. The plan of having the definitions collected at an early stage is excellent, but this should not prevent them being printed in suitable places; for instance, it would be advisable to repeat the definitions of drain and sewer at the beginning of the chapter on the subject. By some oversight, while the Power of Right of Entry and the Public Health (Amendment) Act, 1890, are rightly given in the table of contents as two separate sections, in the body of the book they are printed together.

The illustrations are suitable, but in some—(*e.g.*, Figs. 64, 65, and 66)—it would have been better to have turned them so that the bottom of the picture would have been at the bottom of the page; probably this could have been easily arranged.

But taken as a whole, the authors are to be congratulated on having produced a well-planned and carefully executed book, which should prove of great service to those who are occupied in sanitary work.

ELEMENTARY MICROSCOPY. (b)

THIS is a simple, straightforward, scientific manual for beginners in microscopy. It gives just that practical information and sound, sensible advice which a tyro needs. Lucid descriptions reveal the more important features in the construction of both the simple and compound microscope, and wise suggestions aid in the choice of lens and all accessories. There are also useful chapters on the manipulation of the instrument and methods of mounting. Every medical student is supposed to have a practical knowledge of microscopy, but only too often he works by a mere rule-of-thumb. For these and for all desirous of procuring a working acquaintance with one of the most essential and most delightful means of research we commend this unpretentious but serviceable handbook.

(a) "Errors of Refraction." By Charles Blair, F.R.C.S. Bristol: John Wright and Co.

(b) "Alcoholic Poisoning and Degeneration." By Prof. G. Bunge, M.D., Ph.D. Pp. 27. London: A. Owen and Co. Price 6d. net.

(a) "Sanitary Law and Practice." Robertson and Porter London; The Sanitary Publishing Co., Ltd. 1905.

(b) "Elementary Microscopy." By F. Shillington Scales, F.R.M.S London: Bailliere, Tindall and Cox, 1905. Price 3s. net.

THE BLOOD. (a)

DR. COLE's book on "The Blood" has now reached its third edition—no little compliment to a worker not attached to a teaching school. There can be no doubt felt by any one who reads this volume that Dr. Cole is an enthusiastic and conscientious student of the changes that occur in the blood in the course of disease; but he suffers from the disabilities inherent in the position in which he finds himself, and consequently a good deal of his information is derived at second-hand. For instance, the account given of the Leishman-Donovan body is mostly a quotation from Leishman's own description, and the section Serum-Diagnosis in Typhoid is almost wholly derived from the papers of others. The author excuses himself for not giving his own opinion as to which method for obtaining the latter is the most convenient by saying that typhoid fever is very infrequent in and about Bournemouth. This is very good for Bournemouth, but we should have expected a special work on the blood to have contained a full and adequate discussion on this question, the importance of which, the author says, "cannot be over-estimated." The positive and negative value of the reaction and the necessary degree of dilution deserve ample treatment, and we are surprised that the author did not avail himself of Dr. Horton-Smith's important Gulstonian Lectures to point out the errors that attach to conclusions drawn from low dilutions. The section on the anæmias is, however, exceedingly good, and the differential chart on pages 184–5 admirably carries out a happy idea. Of the coloured plates it is difficult to speak too highly, We have seen many plates lately showing the different forms of corpuscles, red and white, and the blood-parasites, that we thought it hardly possible to improve on; none, however, can compare with these given by Dr. Cole, which in colouring, definition, and artistic reproduction reach the high-water mark of beauty and fidelity. On the whole, this is a very good book, and we can warmly commend it to the notice of those who wish to bring their acquaintance with blood diagnostic processes to the standard of modern knowledge.

LECTURES ON CLINICAL SURGERY. (b)

WE have read through these practical lectures which the author tells us were based upon his notes of lectures delivered to the students in Clinical Surgery, at the Royal Prince Alfred Hospital, Sydney. The lectures are chiefly in connection with Genito-Urinary Diseases, and include such subjects as Strictures, Diseases of the Bladder, the uses of the Cystoscope, Hypertrophy of the Prostate and its removal by the suprapubic and perineal routes, Conservatism in Renal Surgery, Suppression of Urine, the Surgical Aspect of Floating Kidney, and lastly a chapter on Appendicitis. These lectures are not only interesting and instructive, but are most readable, and we hail with pleasure the appearance of such works coming from the pen of Mr. Hinder, an eminent Australian surgeon, who must necessarily have at his disposal any amount of material at the Sydney Hospital to write about, and we hope we may ere long see more from the facile pen of this practical Colonial writer.

COMMON DISEASES OF THE RECTUM AND ANUS. (c)

MR. CECIL LEAF's "Common Diseases of the Rectum and Anus" is a modest little book with a modest little aim. It is only to serve as an introduction to the study of some of the excellent text-books on rectal diseases and to help medical practitioners in diagnosing and treating the maladies with which it deals. Little need be said, therefore, by way of criticism; we notice many omissions, but these are excusable on account of the limited scope of the work. We should have thought the chapter on pruritus ani might have been amplified, and a more extended list of alternative treatments given for this troublesome affection. Notice at least might have been given of Sir Charles Ball's operation. We should be inclined to object to the use of the word "hypertrophied" in an anatomical description of a normal structure such as the internal sphincter; the term should be reserved for increase in the natural size of the part due to the action of an unusual cause. We think that the author generally fulfils the object at which he aims; but that is not saying more than that his little book contains about the same amount of information on diseases of the rectum and anus as is to be found in any standard work on general surgery.

Medical News.

Grocer's Unfortunate Mistake.

THE Manchester County Coroner (Mr. J. F. Price) held an inquiry on the 23rd inst. concerning the death of a Gorton woman, aged fifty-five, the wife of a watchmaker. It was stated that on Monday last she went to the grocer's shop of Mr. Charles Andrews, to buy some castor oil. In mistake she was served with camphorated oil, and after drinking this she was taken ill and died. The husband of deceased told the coroner that just after his wife had drunk the oil Mr. Andrews came running into the house and asked if she had taken the stuff. When told she had, he replied that he had given her the wrong oil, but added that it would do her no harm. She died shortly afterwards. A verdict of death from misadventure was returned..

The Cerebro-Spinal Meningitis Scare.

IN order to allay public alarm over the supposed spread of what is known commonly as "spotted fever," the Local Government Board issued a circular to borough councils and other sanitary authorities of the United Kingdom on Saturday, stating that the disease is not more prevalent here now than it has been from time to time during the past quarter of a century. Though there is at present no unusual spread of the disease in this country, the Board consider it advisable that sanitary authorities should be on the alert against it. The Board also intimate that they are prepared to consider applications from authorities desiring of making the notification of this disease compulsory by extending the Infectious Diseases (Notification) Act 1889 to it for a time.

Data for Determining Physical Deterioration.

THROUGHOUT the Eastern Command the children attending the military schools are being subjected to a medical examination. The senior medical officer at each garrison has to make an examination of the children, whose height, weight, and chest measurement are taken, An average for each age is then prepared, and is forwarded to the War Office. This examination is to be made annual with a view to obtaining some check as to the physical improvement or deterioration of the children.

Proposed Legislative Control over Early Marriages.

DR. J. J. CLARKE, the Medical Officer of Health for Walthamstow, in his annual report just circulated, recommends that the marriage of persons of immature years, and with no knowledge of the responsibility or duty of parenthood, should be prevented by Act of Parliament. First among the main factors producing a high infantile death-rate Dr. Clarke places early marriages, accompanied by ignorance of parents, poverty, and artificial feeding of babies.

(a) "The Blood: How to Examine and Diagnose its Diseases." By Alfred C. Cole, M.D., D.Sc., F.R.S.Edin. Third Edition. London: J. and A. Churchill, 1905.

(a) "Lectures on Clinical Surgery." By H. C. Hinder, M.B., M.Ch., Honorary Surgeon, Royal Prince Alfred Hospital, Joint Lecturer on Clinical Surgery, University of Sydney, N.S.W. Illustrations plain and coloured, 50; pp 286. Price 12s. 6d. London: Baillière, Tindall and Cox. 1905.

(c) "The Diagnosis and Treatment of some of the Common Diseases of the Rectum and Anus." By Cecil H. Leaf, M.A., M.B. (Cantab), F.R.C.S. (Eng.), Surgeon to the Cancer Hospital. London: E. H. Blakeley, 1905. Price, 3s. 6d.

Notices to Correspondents, &c.

☞**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber,' "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

DEATH CAUSED BY YEW LEAVES.

Referring to the annotation on this subject in our last impression, a correspondent writes:—"You say in your comments on the death of an inmate of an asylum from eating leaves of the yew-tree, that you would be glad to hear of any other cases known to your readers. So far as the human being is concerned I know of no case of poisoning, as none but a lunatic would be likely to consume these leaves, but I know of several instances of death in cattle from eating the leaves of the yew, and on my own property a fence of barbed wire has had to be placed round a large tree, in consequence of the loss of cattle from nibbling its leaves. Of course this does not prove that what would be fatal to beast would be so to men, but it at least confirms as a fact the alleged toxic qualities of the yew."

R. S. WILSON.—There are so many good medical dictionaries that it is almost invidious to recommend one more than another. Gould's Illustrated Dictionary of Medicine, Surgery, and Allied Sciences is the most comprehensive, and contains some thousands more words than any other, but if your requirements are more modest and you only need one with words in common use, with the minimum of description, there is the Student's Medical Dictionary published by Mr. Lewis at 7s. 6d., or a still smaller one for the pocket by Messrs. Bailliere, Tindall and Cox at 3s.

D. P. H.—It has been shown that old milk is never quite wholesome even kept at a temperature of 50 deg. F., since, though the bacteria which produce curdling, do not develop abundantly, many other undesirable species grow day after day.

DR. DE P.—We think most medical journals get a fair amount of translations sent in, and these are not very highly paid unless of exceptional interest. We return your MS. with thanks.

M. A. (Salop).—The minimum active dose by mouth of tuberculin is 0·075 min. given on an empty stomach in keratin coated capsules, with a little sodium bicarbonate to neutralise gastric acidity.

OPTICS.—There is a large work which would meet all your requirements—"The Ophthalmic Year Book," by Dr. Edward Jackson. It contains even more information on your subject than the exhaustive *Jahresbericht* of Nagel.

L. S. A.—Our Students' Number, shortly to be issued, will contain all information necessary for students intending to join one or other of the various medical colleges.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, AUGUST 30th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. Russell; Aphasia.

THURSDAY, AUGUST 31st.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—4 p.m. Mr. Armour: Surgical Cases.

FRIDAY, SEPTEMBER 1st.

POST-GRADUATE COLLEGE West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. Abraham: Cases of Skin Disease.

Vacancies.

Metropolitan Water Board.—
Laboratory Assistant.
A Senior Chemical Assistant. Salary £300 per annum.
A Senior Bacteriological Assistant. Salary £300 per annum.
A Junior Chemical Assistant. Salary £175 per annum.
A Junior Bacteriological Assistant. Salary £175 per annum.
Two Laboratory Assistants. Salary £75 each, per annum.
Applications to A. B. Pilling, Clerk of the Board, Savoy Court, Strand, W.C.

The Municipality of the Town of Singapore, Straits Settlements.—Assistant Municipal Health Officer. Salary £400 per annum. Applications to O. C. Lindsay, Esq., M.Inst.C.E., 180 Hope Street, Glasgow.

Connty Borough of Tynemouth.—Medical Officer of Health. Salary £300 per annum. Applications to E. B. Sharpley, Town Clerk, Town Hall, Tynemouth.

Hospital for Sick Children, Newcastle-on-Tyne.—Male Resident Medical Officer. Salary £100 per annum, with board, lodging and laundry. Applications to Alf. E. Birch, Secretary, Secretary's Office, Hospital for Sick Children, City Road, Newcastle-on-Tyne.

County Lunatic Asylum, Lancaster.—Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

The University of Mebourne.—Professor of Anatomy. Salary £900 per annum. Applications to the Agent-General for Victoria, 142 Queen Victoria Street, London, E.C.

Lanark District Asylum.—Third Assistant Medical Officer. Salary £120 per annum, with fees, &c. Applications to Neil T. Kerr, Medical Superintendent. (See Advt.)

Appointments.

KIDD, MARY, M.B.Lond., Junior Resident Medical Officer to the Canning Town Medical Mission, London, E.

SKRIMSHIRE, C. P. M.R.C.S.Eng., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Blaenavon District of the county of Monmouth.

THOMPSON, ALEXANDER DEY, M.B., Ch.B.Glasg., Senior Assistant Medical Officer to the Monmouthshire Asylum, Abergavenny.

Births.

ANDERSON.—On August 19th, at Grinshill, near Shrewsbury, the wife of Frederick T. Anderson, M.D., of a daughter.

BARRETT.—On August 23rd, at 56 Manor Road, London, the wife of Sidney Edward Barrett, M.B., of a son.

MELDON.—On August 21st, at 123, Morehampton Road, Dublin, the wife of Dr. Pugin Meldon of a daughter.

PATERSON.—On August 23rd, at Stirling Lodge, Farnborough, Hants, the wife of Charles E. Paterson, M.D., of a daughter.

POCOCK.—On August 22nd, at Beaconsfield, Bucks, the wife of A. R. G. Pocock, M.D.Lond., of a son.

Marriage.

DENYER—WILSON.—On August 23rd, at Holy Trinity Church, Kendal, Stanley Edward Denyer, C.M.G., M.A., M.D.Cantab., second son of Alfred Denyer, St. John's Lodge, Eastbourne, to Sarah Irene, daughter of Forster Wilson, Monument House, Kendal.

Deaths.

ADAMS.—On July 29th, at Winnipeg, Francis George Adams, aged 36. third son of Dr. James Adams, of Denmark Villas, Hove

LINDSAY-WHITE.—On August 18th, at 3 Southfield Road, Bedford Park, W., Emilie Frances, beloved wife of Percival Lindsay-White, and third daughter of the late Dr. R. St. John Lyon, Dalkey.

MUDD.—On August 26th, at Chichester, Frederick Charles Mudd, M.R.C.S., L.S.A., son of the late William Mudd, M.D., of Hadleigh, Suffolk, aged 65 years.

OPERATIONS—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopædic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9 30 a.m. and 2 30 p.m.), Gt Ormond Street, 9 30 a.m.), Gt. Northern Central (2 30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat 9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynæcological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Spuare (9.30 a.m.), City Orthopædic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St George's (1 p.m.), St. Mary's (10 p.m.) Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.35 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynæcological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopædic (2 p.m.), City Orthopædic (4 p.m.), Great Northern Centre (2.30 p.m.), West London (2 30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m., St. Bartholomew's (1 30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.) Throat, Golden Square (9 30 a.m.), Soho Square (2 p.m.).

PRACTICE.—Wanted to Purchase a small practice, near Dublin. Sea-side preferred. Reply to B. B., care of MEDICAL PRESS AND CIRCULAR, 16 Lincoln Place, Dublin.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, SEPTEMBER 6, 1905. No. 10.

Original Communications.

THE MECHANISM OF ANGINA PECTORIS.

By FRANCIS HARE, M.D.,

Consulting Physician Brisbane General Hospital: Visiting Physician Diamanta Hospital for Chronic Diseases, Brisbane.

IN two recent articles (1) it was argued that in their mechanism, the dyspnœa of asthma and the pain of migraine conform to one common principle, in that both these dominant symptoms are essentially vaso-motor and depend upon localised vascular distension due to localised vaso-dilation, compensated and intensified by widespread peripheral vaso-constriction. In the present article it will be argued that many cases of angina pectoris depend essentially upon a similar vaso-motor mechanism; that there is a widespread peripheral vaso-constriction, compensating and intensifying a localised vaso-dilation; and that the resulting localised vascular distension is the proximate factor of the dominant symptom, namely, the distinctive breast-pang or cardiac and radiating pain.

In both asthma and migraine the localised vaso-dilation is well recognised by those who accept a vaso-motor explanation of these paroxysms. The correlative vaso-constriction, on the other hand has received but scant notice from a few, and by most of those few has been seemingly regarded as incidental, not essential. Angina, however, stands differently in these respects. That peripheral vaso-constriction occurs in many cases is freely admitted; while the correlative localised vaso-dilation has been, so far as I can discover, completely ignored, if not unsuspected. And yet all the circumstantial evidence which can be brought to bear on the subject tends to the view that the mechanism of angina in many cases runs a strict parallel with the mechanism of asthma and migraine.

Nothnagel recorded a series of cases which tend to show that a sudden increase of tension in the peripheral arteries due to a cause acting upon the body from without is capable in some persons of giving rise to phenomena approaching those of a paroxysm of angina pectoris . . The earliest and most conspicuous symptoms of the paroxysm . . . were coldness and pallor with numbness and stiffness of the limbs; the palpitation, feeling of oppression at the chest, the giddiness, the sense of impending death, being all secondary and attributable to the increased efforts which the heart is called upon to make to overcome the peripheral resistance (2). The coldness and pallor of the limbs is objective evidence of cutaneous vaso-constriction; while in many cases palpation of the radial and other arteries shows them clearly to be tightened up.

The importance of peripheral vaso-constriction —that is, vaso-constriction in areas other than the seat of pain production—may be inferred from many observations. External cold promotes cutaneous vaso-constriction; and in Nothnagel's cases the attacks were "definitely traceable to external cold" (3). Anstie refers to an extraordinary circumstance reported by Guélineau in the *Gazette des Hopitaux* for 1861, namely, "an epidemic outbreak of angina in which numbers of men belonging to a ship's crew, were simultaneously affected . . . the powerful exciting cause seemed to be the rapid change from a very hot to a very cold climate" (4). The hasty swallowing of cold water will, according to Fagge, induce a paroxysm of angina in some cases (5). As pointed out in the case of asthma, emotion, especially fear, whch is commonly associated with cutaneous vaso-constriction, is very apt to determine paroxysms. The same is true of angina: it will be freely admitted that fear is a common excitant of anginal seizures.

Many fevers are associated during their invasion stage with marked cutaneous vaso-constriction; and I have twice known anginal seizures, in persons pre-disposed by previous attacks, precipitated by the onset of fever. In both instances the fever responsible was influenza. But the fever most markedly and constantly associated with cutaneous vaso-constriction is malaria. In the malarial rigor intense vaso-constriction of the skin is an essential feature; and not a few cases are recorded in which the onset of ague precipitated typical anginal seizures. Anstie saw such himself. He also refers to several original and quoted cases in Handfield Jones' "Functional Nervous Diseases," 2nd ed. 1870 (6). And Broadbent mentions a case in which "serious weakness of the heart was left behind for some time" (7).

While it is thus clear that conditions which promote peripheral vaso-constriction are often capable of inducing anginal seizures, it is easy to show that conditions which promote peripheral vaso-dilation are often capable of dispersing anginal seizures. The vaso-dilation may be general, or it may occupy any other area than the seat of pain production. Amyl nitrite inhalation promotes general vaso-dilation; and Lauder Brunton showed that this drug gave instant relief from the pain of angina in, I think, the majority of cases (8). Nothnagel's cases "were relieved by hot foot-baths and frictions" (9). In several of my cases, the application of hot foments to the chest, back, and front gave instantaneous relief; the hotter and more extensive the application the greater the relief. In some the relief so afforded was quite equal to the relief afforded by amyl nitrite. In several cases sipping hot water or any hot fluid has been quite successful.

It is only at the onset of continued fever and during the first stage of the ague paroxysm, that cutaneous vaso-constriction occurs. Generally speaking, "arterial relaxation is the condition of the vessels characteristic of pyrexia" (Broadbent (10). For which reason, in all probability, fever, during its continuance, tends to prevent the recurrence of habitual anginal seizures, just as it does the seizures of habitual migraine (11) and habitual asthma (Trousseau, 12).

Some four years ago Walter Whitehead made the somewhat startling announcement that he had "never failed to treat successfully the most inveterate and severe cases of migraine by the introduction of an ordinary tape seton" (13), such to be worn for a more or less prolonged period. In a work entitled "The Food Factor in Disease" (14)—which is now in private circulation, but which will shortly be published—I have, I think, succeeded in showing that the seton acts in such cases, not through counter-irritation, derivation or revulsion (whatever the exact significance of those terms), but through a mild grade of septic pyrexia. Conformably, I have given cases which show that the average rectal temperature tends to be raised, usually by from ·5 to 1°F. through wearing a seton, and that the site of insertion is a matter of complete indifference as far as concerns the relief from migraine. And on a future occasion I hope to show that the occurrence of suppuration is by no means always to be regarded as an unmixed evil. Now in this connection it is interesting to learn that David MacBride (A.D. 1776) permanently cured one, and Erasmus Darwin (A.D. 1796) four cases of angina pectoris by the prolonged use of femoral issues (15).

It is, of course, through causing a tendency to rise in aortic blood-pressure that peripheral vaso-constriction induces anginal paroxysms. Hence conditions other than peripheral vaso-constriction which have a like tendency, may induce paroxysms. Physical exercise at its commencement causes, if violent, a rise in blood-pressure amounting to 20 mm. Hg. (Leonard Hill, 16). This is ascribed to widespread compression of the muscular veins. Whether this be true or not, it is a fact that sudden exertion is prominent amongst the immediate antecedents of anginal seizures. But much depends upon the circumstances which surround the exertion. These are sometimes such as introduce additional cause of rise of blood-pressure. Exposure to cold tends, as already argued, to cause rise of blood-pressure through cutaneous vaso-constriction. A meal, more especially, of course, a heavy meal, is followed by a distinct rise of blood-pressure (George Oliver, 17). And there is no more certain means of inducing a seizure in one who is pre-disposed to angina than hurriedly starting to walk up-hill in the teeth of a strong, cold wind when insufficiently clad and soon after a heavy meal. Indeed, this combination of factors may lead to a very excellent imitation of an anginal seizure in one who suffers in no other circumstances. The writer has manufactured such a seizure in his own person.

But physical exercise has a double influence on blood-pressure. The initial rise lasts for some fifteen minutes, and then there sets in a fall (Leonard Hill, 18). The fall is ascribed by Clifford Allbutt to general arterial dilation in the extensive muscular layer. In exact conformity with the secondary influence of physical exercise on blood-pressure is the secondary influence of physical exercise on angina. Fagge remarks in this connection:—"It is . . . a curious fact that some persons, after being pulled up by the pain three or four times at the beginning of a walk, will afterwards go on with ease for several miles" (19). This, in my experience, is really the rule, not the exception, as might perhaps be inferred from Fagge's words: of this anyone can assure himself. A lady of 25, who has no organic cardiac disease, suffers from frequent angina. This she can defer indefinitely by regular physical exercise. But sometimes she hurriedly starts to walk when an attack, which in her case commences somewhat insidiously, is impending. The effect is to increase the pain for the first three-quarters of a mile; then the pain rather quickly abates and ceases entirely, *nor does it ever recur during the continuance of the exertion, no matter how severe this may be.* In fact, this patient actually walks off her impending angina, just as others not infrequently walk off impending asthma and impending migraine (20).

It is, of course, unquestioned that many who suffer from angina suffer also from organic heart disease, and that angina, especially when so complicated terminates not rarely in sudden death. But it does not follow, nor has it ever been demonstrated, that the organic lesion is amongst the essential factors of angina. As Fagge says:—"The long duration of the disease in some cases seems inconsistent with the idea that any of the organic lesions . . . can have existed throughout its whole course. Possibly—"—why not probably?—"the paroxysms of angina owe to the lesions in question their severity and their tendency to prove fatal, but do not stand to them in the direct relation of effect to cause" (21). It would seem more reasonable in these complicated cases to ascribe the organic lesions and the anginal seizures to a common factor, namely, prolonged continuous or intermittent rise of blood pressure; nor would this preclude us from assuming that every seizure adds something to the organic damage.

The view suggested by Fagge receives strong support from a consideration of the life history of many cases which present the long observed, but hitherto unexplained, phenomena, of "alternating neuroses." Into this question it is impossible to enter now. But it may be observed that migraine, asthma, and other paroxysmal neuroses have not rarely been observed to alternate, or have completely inverse relationships, with angina throughout the life history of the same patient. I have watched the case of a personal friend for eighteen years. For six years he suffered from irregularly recurring "spasmodic" asthma. At the end of this period he began to suffer from anginal seizures. As these became frequent and severe the asthma gradually became less frequent and severe. Then for three years he suffered from angina only; and the seizures were typical and intensely severe. At the end of this time the angina ceased absolutely, and in its place he suffered from severe recurrent sick-headaches. Some years later, his sick-headaches having subsided, his angina returned with great severity. It would have been impossible for any physician who saw him during a seizure to speak of "pseudo-angina." The attacks were so violent that the patient usually became sub-conscious, if not unconscious, and were succeeded by symptoms pointing to cardiac weakness. Yet the whole history of the case is, I maintain, incompatible with the view that the angina any more than the asthma or the sick-headaches, depended essentially upon some undiscoverable cardiac lesion.

As long recognised, seizures indistinguishable from typical anginal seizures, may arise through flatulent distension of the stomach. In a case of my own each attack came on shortly after meals; the pain was intense, its character and distribution typical. There seemed to be no peripheral vaso-constriction, and nitrites gave no relief. But instant and complete relief followed gaseous eructation, however brought about. Such cases are apt to be termed pseudo-angina. But for this there seems no adequate justification. By gastric distension the heart is "actually tilted upwards upon itself" (Lauder Brunton). Such would probably cause increased resistance in the aortic outflow; and the result would be a rise of aortic blood-pressure. Thus gastric distension would operate to cause angina in a manner similar to peripheral vaso-constriction. But the obstruction would be differently situated and would consequently require different treatment.

In the view taken in this article, the tendency to rise of blood-pressure which occurs in angina is compensated wholly or in part (as in the parallel cases of migraine and asthma) by an internal vaso-dilation; the vascular distension so determined is the proximate factor of the pain; and the site of the vascular distension is in all probability the coronary area, and quite likely certain adjoining areas.

From observation of cutaneous vaso-constriction, there is a general tendency to infer a like condition in internal vascular areas; and it must be admitted that the physiological principle of compensation implied in correlative areas of vaso-constriction and vaso-dilation, has not been widely applied to the elucidation of pathological problems. For these reasons probably, and from the frequent occurrence of obliterative disease of the coronaries in fatal cases, anginal seizures have been ascribed to vaso-constriction or intermittent spasmodic closure of the coronary vessels with consequent ischæmia of the cardiac muscle (Huchard). But there are objections to this view one of which seems fatal. In the first place, vaso-constriction and ischæmia are not as a rule associated with pain, but with numbness and depressed sensibility; vascular distension is on the contrary a common cause of pain. Secondly, the heart muscle is supposed to be called upon to perform additional work during anginal seizures; and all other muscles so situated have their arterial blood supply increased through vaso-dilation, not diminished through vaso-constriction. Finally, the recent experiments of Schäfer render it highly improbable that the coronary arteries are provided with vaso-motor fibres, either constrictive or dilative (21). This conclusion would, of course, preclude both vaso-constriction and *active* vaso-dilation of the coronaries as a proximate cause of angina. But it would not preclude an intense passive dilation of these vessels. Indeed, an abscence of all vaso-constrictive impulses would render the coronary arterial system peculiarly susceptible to any increase in peripheral resistance.

Persistent or frequently recurring strain of the coronaries through passive dilation would amply account for the arterio-sclerotic or obliterative disease so frequently found in these vessels. Vascular distension of the adjacent cardiac plexus would account for the radiating pain in anginal seizures. And the prolonged recurrence of vascular distension in this situation would account for the evidences of neuritis in the cardiac nerves demonstrated by Lancereaux, Peters, and others. Indeed, much evidence could be adduced to show that recurrent vascular distension of nerves and ganglia is the basis of many neuralgias (tic douloureux, sciatica, etc.), and that these ultimately graduate into neuritis.

In migraine, evidence of the localisation of the internal vaso-dilation was found in the relief afforded by compression of the arterial trunks leading to the dilated area. In both migraine and asthma, evidence of the same was found in the relief afforded by the direct application of cold to the dilated area. In angina no such approximately direct means of demonstration is available. But much circumstantial evidence offers itself.

The vascular distension of the coronary and adjoining areas can only be maintained by the driving force of the left ventricle acting against the peripheral resistance. A decrease in the operation of either of these fundamental factors will relieve the vascular distension, and consequently the angina. We have already seen the anginal seizure relieved by decrease of the peripheral resistance, achieved in numerous ways. It remains to show that angina may be relieved by decrease in the driving force of the left ventricle.

Syncope implies decrease in the driving force of the left ventricle; and syncope may be observed in some cases to come to the relief of angina, just as it does at times to the relief of migraine, if not to the relief of asthma. One of my patients suffers at times from syncope as well as from angina. Both varieties of seizure are associated with cutaneous vaso-constriction; and both are promptly relieved by amyl nitrite inhalation. Consequently it is reasonable to believe that the essential difference between them consists in the mode of compensation for the increased peripheral resistance. In the angina the compensation is by vaso-dilation; in the syncope by reduced ventricular force. This view receives further compensation by the fact that on some occasions a partial syncope supervenes on, and supersedes, an anginal seizure.

Again, it is certain that the driving force of the left ventricle depends very largely upon the integrity of the mitral valve. Mitral insufficiency will greatly impair the driving force of the ventricle, and by so much will diminish the probability of areas of vascular distension. Conformably, Broadbent has placed it on record that "the supervention of mitral regurgitation may . . . greatly diminish the liability to attacks in cases of angina" (23). He adds that the future course of the disease may be entirely changed. The view of the mechanism of angina herein propounded has not, so far as I can discover, been hitherto entertained; this seems amply accounted for by the omission from pathological speculation of the physiological principle of compensation implied in correlative areas of vaso-constriction and vaso-dilation. The view may, of course, be largely—it can hardly be entirely—incorrect. Yet this much may be safely said:—It conforms with the vaso-motor mechanism of those closely-related paroxysmal neurosi, asthma and migraine; it is consistent with the natural history of the disease and with all the means of relief in common use; and it leads directly to new and rational methods of treatment, preventive, palliative, and curative. Consequently it demands the serious consideration of the profession.

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French Clinical Lecture.

ON FLUCTUATION. (*a*)

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[SPECIALLY REPORTED FOR THIS JOURNAL.]

ONE of the difficulties with which beginners are met in practice is to satisfy themselves of the presence of fluctuation, a difficulty from which even experienced practitioners are not exempt. I remember a case in my young days in which my chief, having examined an abscess, confidently declared that fluctuation was present. I carefully followed his instructions as to the mode of examination and paid particular attention to the impressions conveyed thereby, but a few days later I was surprised not to be able to elicit the same phenomena either in a patient with ascites or in one with hydrocele. In both these cases, however, my chief had pronounced the word "fluctuation." My uncertainty was aggravated when, in discussing a lipoma, he referred to what he called "false fluctuation." I consulted my books, which appeared to me to throw very little light on this point. As you too may have found yourselves confronted with the same kind of hesitation, I have chosen this subject as my theme for to-day.

The principal cause of this misunderstanding is the assumption on the part of the inexperienced that a particular word must needs convey a particular sensation. Now this is not the case, for the word fluctuation applies to many and widely different sensations. It may, therefore, be well if I commence by formulating the following definition "the word fluctuation is applied indifferently to the various sensations that the surgeon perceives in presence of a collection of fluid in the tissues." No doubt it would have been better to give each sensation its special name, but since universal custom has rendered the word fluctuation intangible we must fain employ it, though there is nothing to prevent our studying in detail its many modifications.

1. There is one to which the word fluctuation applies very accurately, in fact the word "undulation" would have been preferable to the former. Unfortunately for nomenclature this variety is quite exceptional. Its production infers the presence of fluid in a large cavity with pliable walls. Such collections only exist in ascites, traumatic serous effusions and certain ossifluent tumours. When we tap such a tumour the eye sees and the hand feels the wave of the fluid which undulates in every direction; the wall of the tumour "floats and trembles to the naked eye" as if a series of small waves were passing beneath it, making it rise and fall.

2. A second kind of fluctuation, even rarer than the preceding, and altogether different therefrom, is the sensation of shock. We only get this in ascites, and for its production there must be a large collection of fluid and the cavity must be well filled, a striking contrast to the preceding conditions. Under these circumstances, when the surgeon gives a sharp tap or flick on one part of the tumour, the other hand, applied flat on the opposite side, immediately perceives a short, sharp shock, the strength of which is directly proportional to the impact. Chassaignac, one of the few authors who endeavoured to classify the sensations of fluctuation, observes that of the various signs, undulation and shock are alone pathognomonic of a collection of fluid in the tissues. The other varieties leave room for doubt, and may even lead one astray, and in any case the sensation must be very clear to justify the diagnosis.

3. A third kind of fluctuation is described as the return shock. It is met with in certain deeply seated collections not readily accessible to the finger; or where the sac containing the liquid lies upon a bone. A peri-pharyngeal abscess is the classical example of this kind. In this case the posterior wall of the pharynx is raised by an exudation between it and the bone. The finger is introduced through the mouth and made to come into sharp contact with the tumour. To begin with, the finger depresses the tumour, but if the finger, suddenly arrested, be met by a return wave we are justified in assuming that the tumour contains fluid. The pus

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(*a*) *Gaz. des Hop.*, March, 1905.

displaced by the examining finger has come into contact with the hard posterior wall of the pharynx which sends it back and it impinges on the finger.

4. A fourth, less known, variety is characterised by a sensation of retreat. This is felt in the big natural cavities, such as the thorax and abdomen, in collections having several "pockets," or with numerous diverticula, in suppurations such as the diffuse phlegmons of the limbs, &c. We press on the tumour, which does not resist; the wall sinks in and the contents go elsewhere. The mechanism is easy to understand; the deep cavities are big and only slightly distended, but the least internal pressure suffices to cause the passage of the contents of the superficial into the more deeply situated pockets. All abscesses communicating by a small opening or into separate cavities are capable of yielding this sensation, and I have twice met with it in cases of suppurative peritonitis, the exudation whereof distended a disused hernial sac. The general symptoms have led us to suspect strangulated hernia, but on the least pressure the voluminous inguinal tumour subsided into the belly.

5. A fifth variety is met with in certain abscesses of the mammæ which give the sensation of a trephine opening. The pulp of the exploring finger enters an aperture, usually of narrow dimensions, a fifth of an inch at most in diameter, with a hard, resisting border. Here again you may, on pressure, obtain the sensation of retreat, but if then you seize the whole breast with the other hand and exert compression the finger is, on the contrary, upraised. You understand, I hope, that the liquid—pus in all probability—which has perforated the mammary capsule and has extravasated outside it, is forced back into the original cavity when the finger presses upon it and *per contra* returns to the more superficial situation when the deeper cavity is rendered tense by pressure.

6. A sixth and much more important variety, the one most frequently met with in practice, is altogether distinct from those previously described, *viz.*, fluctuation by seesaw or counterpoise. To appreciate this sensation one finger of the right hand is placed on the tumefaction and a finger of the left hand is also placed thereon, at a greater or less distance according to the size of the tumour. Pressure exerted with the right finger is perceived by the left finger which is raised. *Vice versâ* the manœuvre may be repeated by pressing with the finger of the left hand when the right finger will be raised. You see then that it is possible with these two fingers to create a movement of alternative or seesaw counterpoise, which is called fluctuation, although it has nothing in common with the signs already described.

This fluctuation by seesaw or counterpoise may be compared to the form of fluctuation by pinching, thus named by Chassaignac. This can only be obtained in very prominent tumours, such as certain præ-patellar hygromas, hæmarthroses or hydrarthroses and in pedunculated collections, such as cysts of the cord, of the epididymis and of the tunica vaginalis. To obtain it we must seize a segment of the tumour between the thumb and index finger of the hand and another segment between the thumb and index finger of the other hand. When we squeeze with the fingers of one hand we feel that the fingers of the other hand are separated. This variety, however, hardly amounts to a separate variety, for after all it is only a form of fluctuation by seesaw.

This remark applies equally to the plan adopted in deep-seated suppuration of the limbs. For instance, to obtain the sensation of fluctuation in a sub-muscular abscess of the thigh muscles we apply the palms of both hands flat upon the thigh at some distance one from the other. We press with one hand, and in presence of a deeply seated abscess we soon feel that the other is raised by "a rounded supple body" that projects from beneath. But you will note that this plan after all is only a further application of the seesaw sign, the palms of the hands replacing the pulp of the finger.

The liquid thus shown to be present is usually pus. All phlegmons, glandular abscesses of the limbs, trunk, and head give us this sensation of seesaw as soon as the pus has collected. Blood-containing cavities, hæmatomata, yield a similar sensation as do also the serous cysts. You must not, however, go away with the idea that in every case of collection of blood or pus you will obtain this sensation of seesaw. Not to go farther afield than cysts of the breast, if the cyst happens to be tense and of small dimensions, with a thick wall or covered with a sufficiently thick layer of glandular tissue, the cyst does not fluctuate, there is no seesaw motion, the tumour has a wooden resistance which often leads to its being mistaken for a neoplasm even by experts.

Nevertheless, this seesaw motion remains a very valuable sign. It was especially so in former days when an inopportune incision might determine the death of a patient, when it was all important only to operate on certain data; consequently, the question concerning fluctuation was then regarded by examiners as of capital importance. Though less important nowadays it is absolutely necessary to recognise and distinguish false fluctuations.

You may be aware that when we press with the finger end on certain muscular masses, on certain solid tumours, lipomata, medullary sarcomata, soft lymphadenomata, myxomata, spongy masses of white tumours, &c., a very distinct sensation of fluctuation may be perceived. It has been insinuated that in such a case the error must be due to want of care in the examination, and Chassaignac asserts that with "tact and experience" we ought always to be able to distinguish between true and false fluctuation.

My own opinion is rather in flavour of that expressed by Trelat, who was a great master in diagnosis, that such shades of difference are non-existent, and that even experience and tact will not enable us to distinguish between the two since they are practically identical. I myself have seen him make mistakes of this kind and plunge a trocar up to the hilt into a scrotum distended by a soft sarcoma under the impression that it was a hydrocele. Yet, who more than this great teacher possessed the two qualifications indicated by Chassaignac as necessary for the avoidance of error—tact and experience?

Let us take the classical example of the fluctuation of a cold abscess and the false fluctuation of lipoma. Surgeons who pretend to distinguish between the two as often as not go wrong. Palpation gives the same sensation of seesaw fluctuation, just as precise and distinct in the one case as in the other. If then they manage to arrive at a correct diagnosis between the two conditions it is because they have availed themselves of other concomitant signs : cutaneous thickening, lobulation of the tumour, indolence or pain, or the mode of evolution. The fluctuation urges them to say here there is the liquid, but their judgment intervenes and suggests the idea of a solid tumour, and, it may be unconsciously, modifies their first impression and leads them to describe it as " false '" fluctuation.

What a number of stories I could relate to show that the cleverest, the most experienced, the most erudite, make mistakes, and are unable to distinguish between true and false fluctuation. One day Dr. Denonvilliers placed on the table of the Surgical Society a subcutaneous tumour, widely excised on a dead subject. Was it a lipoma or a cold abscess ? The surgeons present examined the tumour one after the other, tried to elicit fluctuation, and ultimately half of them opined one way and the other half the contrary. No one was prudent to declare that the problem was one that could not be solved merely by trying to obtain fluctuation.

I have seen an even better example. Thirty years ago a certain surgeon, curator of the Dupuytren Museum, incised a tumour on a patient's forearm which he believed to be a cold abscess. A mass of fat protruded through the opening so that he took it to be a lipoma, and the patient was sent into Broca's service for its complete removal. Broca, who held to the view that it was possible to distinguish between true and false fluctuation, delivered a little lecture on the case to explain to us how his colleague had fallen into error, and he repeated that with tact and experience such errors could be avoided. He then proceeded to free the tumour, when all at once there was a rush of pus that spurted all over him. The lipoma was really a cold abscess covered with a fatty envelope, which the original operator had been too timid to pierce.

In short, gentlemen, fluctuation and false fluctuation are two different words that describe a single sensation, and I will conclude my remarks by repeating my definition that under the term fluctuation we group a number of sensations which, though widely different from each other, reveal to the exploring finger the presence of a collection of fluid in the tissues.

THE PART PLAYED BY SHELL-FISH IN THE INCIDENCE OF TYPHOID FEVER. (*a*)

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The writer first quoted from a paper he read before the Epidemiological Society of London in April, 1903, on "The Seasonal Incidence of Typhoid Fever and of Diarrhœa," in which he adduced evidence and arguments in favour of his thesis that "the seasonal incidence of typhoid fever in this country, particularly in well drained towns possessing a wholesome water supply, has a closer relationship with the consumption of infected shell-fish than with any meteorological or geological phenomena." (*a*)

Since constant publicity has been given to the dangers of polluted shell-fish of all kinds (oysters, cockles, mussels, clams, &c.) during the last two years, there has been a very marked diminution in the amount of typhoid fever, not only in his own district, but in London and elsewhere.

Since June, 1902, Dr. Nash has been almost monthly reporting to the Southend Town Council on the dangers of partly cooked cockles taken from the bed of a creek in an adjoining district, into which creek the sewage effluent of a town of 4,000 inhabitants discharges. He quoted statistics which showed that during the first nine months of 1903 the incidence rate of typhoid fever in his district was only 0·5 per 1,000, as compared with an average incidence rate of 2·0 per 1,000 for the same months in the nine previous years. Seventeen out of the eighteen cases which occurred during this period in 1903 gave a history of shell-fish. From the facts Dr. Nash made the deductions—

1. That in spite of the warnings he gave from time to time there were still some persons who ate polluted shell-fish.

2. That the numbers of such persons had, however, been materially reduced.

3. That apart from polluted shell-fish, typhoid fever would be almost unknown in Southend.

A remarkable outbreak took place among some labourers engaged on a new sea-wall. Most of these labourers were imported, and many of them had not heard anything of the local stir about shell-fish. About 40 per cent. of these men partook of oysters from a source open to pollution. About 60 per cent. did not partake of the shell-fish. Several cases of typhoid fever occurred among the smaller percentage who were indulging in shell-fish. No cases occurred among the larger percentage that did not partake of the shell-fish. Apart from the shell-fish the conditions of environment were common to the whole lot. Personal warning to each gang and the exhibition of printed notices of warning brought the outbreak to an abrupt termination within ten days or so. Prior to this, one navvy returning to East Ham for the week-end took up some of the oysters to his friends. About twenty persons in East Ham were said to have eaten the oysters, and nine or ten of these persons (or about 50 per cent.) were stated to have contracted typhoid fever two or three weeks later.

Dr. Nash has been making systematic inquiries into whether shell-fish have been eaten or not in dealing with every case of infectious disease notified since 1902. He was able to show that among 830 cases of other infectious disease notified during the three years 1902, 1903 and 1904, shell-fish had been eaten by less than one person in every hundred. On the other hand, among 149 cases of typhoid fever notified during the same period, no less than 62 per cent. had recently partaken of shell-fish, while a considerable proportion of the remaining 38 per cent. were secondary to shell-fish cases, and therefore indirectly attributable to shell-fish. As a considerable proportion of the cases of "other diseases" were adolescents or adults, and a considerable proportion of the "typhoid fever" cases were

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(*a*) Abstract of Paper read at the Leicester meeting of the British Medical Association.

(*a*) "Transactions" of the Epidem. Soc., vol. xxii., 1902 & 1903.

children, there was no very material difference in the age incidence of each group.

Dr. Nash then exhibited some diagrams he had constructed to show the diminution of typhoid fever in Southend since Sir Wm. Broadbent's communication to the *British Medical Journal* in 1895 began to put medical men on the "qui vive" as to the causal relationship of oysters from polluted sources. He showed that striking an average for the next ensuing three years there was a remarkable reduction in the incidence of typhoid fever, though no change in sanitary conditions had been effected.

In 1897 the Corporation instituted a house-to-house inspection, and in 1898 a new sewage scheme came into use. A further reduction in typhoid fever was noticeable during the next ensuing three years, but Dr. Nash is inclined to attribute a considerable proportion of this further reduction to an increasing knowledge on the part of the profession and the public as to the dangers of oysters. In spite, however, of sanitary improvements and of a lessened consumption of polluted oysters an undue amount of typhoid fever still prevailed in the borough when the author became Medical Officer of Health in 1901. His inquiries soon made him suspect partially cooked cockles from a polluted source. A definite outbreak in June and July, 1902, enabled him to clearly inculpate and denounce these parboiled cockles which hitherto had been supposed to have had all evil scalded out of them. Dr. Nash's researches in this direction are embodied in a paper in the "Journal" of the Sanitary Institute, vol. xxiii., 1902. In spite of much local opposition he firmly and repeatedly warned the public against eating cockles from polluted or unknown sources. Shortly subsequent to this, the Annual Report of the Medical Officer to the Local Government Board appeared in print embodying the results of experiments made by Dr. Klein on partly-boiled cockles which conclusively demonstrated that the bacillus typhosus could survive the methods of cooking then in use. The local dealers became in time convinced and adopted improved methods, getting the cockles from purer sources and steaming them thoroughly for several minutes.

The sequel has been of the happiest nature. The reduction in the incidence rate in Southend has been one of nearly 90 per cent., while a marked diminution is noticeable in London, where many hundreds of gallons of cockles are consumed yearly. These results are naturally to be viewed with the greatest satisfaction. The large part played by flies in carrying infection during the summer months was then briefly alluded to, and it was incidentally remarked that the original source of the infective material though difficult actually to identify is, nevertheless, easily comprehended when it is remembered that 25 per cent. of typhoid fever convalescents excrete living typhoid bacilli in the urine for weeks or even months after convalescence, as pointed out by Dr. Horton Smith (*a*) in 1900. The author urges this fact as a reason for treating all typhoid convalescents with urotropin prior to discharge; or, at any rate, that the urine should be examined systematically for typhoid bacilli before considering or certifying a patient as safe from infection.

(*a*) Goulstonian Lectures, 1900.

HYGIENIC TEACHING AND TRAINING AT SCHOOLS. (*a*)

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Little apology need be offered for a short paper which deals with a matter of such national importance as that of hygienic training and teaching in schools; for we are all too painfully aware of the large amount of wasted health, energy, and life which results from ignorance and neglect of the laws of health, and which apart from the misery it entails, constitutes a heavy economical loss to the State.

The ignorance among the poor of household management and of the principles of hygiene is responsible in no small measure for their high preventable mortality, their inferior physique, their intemperance, and their poverty. The radical cure for these evils is a suitable hygienic education, moral and material; and we ought not to allow our middle and better classes attending school to "complete their education" without the knowledge of a few important facts of hygiene which can to a great extent determine their future health, happiness, and usefulness.

If it were necessary to make an apology at all, it would be on the grounds that one hears such varying opinions of what the scope of this hygienic instruction should be that it seems desirable still to discuss the subject until the best and most workable scheme has been evolved. What we want is, in the words of the late Sir John Simon, "that education which by model and example, would lead the poorer classes of society to know cleanliness from dirt, decency from grossness, human propriety from brutish self-abandonment . . . an education which would teach them to feel the comfort and profit of sanitary observances, and would apply their instincts of self-preservation to the deliberate avoidance of disease. The need of bodily health as the foundation of sound mental work is recognised, and the training and teaching of children to observe those habits of cleanly decency which are the very basis of a healthy life, and the care for the hygienic environment of the scholar, are grave responsibilities attaching to all those to whom young lives are entrusted."

The school régime must be made to afford every opportunity for healthy bodily development, not only by training the scholars in suitable physical exercises and in encouraging them in a good selection of games, but also by continually presenting an object-lesson of the recognised importance of fresh air, cleanliness, &c. The teacher can do much by example, precept, and personal influence to create a sanitary conscience among the rising generation. To these ends he should enlist as far as possible the co-operation of parents in the home, and he should bring, if possible, his personal influence to bear upon them in certain cases. The training in the observation of sanitary precepts is a form of moral training, and if the home influences are antagonistic to those of the school the home influence will often prevail. A dirty and neglected child indicates the necessity of attempting to do something to improve the parents. The child will often be the medium for this parental education, but sometimes the local sanitary authority may be used with advantage, especially if it has a female health visitor in its employ.

There is, of course, a very wide distinction to be drawn between what the teacher should know and practise and what the scholar should be taught and trained to do; and in drawing up a detailed syllabus for the latter we have only to ask ourselves at every step, Is it essential that he should know this? Is it knowledge which he or she can apply? In my opinion it is a wicked and stupid waste of time to teach scholars

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(*a*) Abstract of Paper read in the Section of State Medicine at the Leicester Meeting of the British Medical Association, 1905.

under fourteen years of age the structure of the lungs and the mechanism of respiration. In order to impress upon them the importance of fresh air it is sufficient to base the teaching on the results of common experience and a simple experiment with a candle.

It is almost sufficient to impress upon the scholar certain rules upon healthy living and to give reasons for them; and at the same time to train him in hygienic habits while at school. It is often contended that the youth of the scholars and the limited time available, render adequate treatment of so extensive a subject as hygiene impossible. The justness of the contention depends entirely upon what is regarded as *adequate*. In my judgment of what is adequate the subject could be sufficiently taught at the cost of only one half hour per week during the last two years of compulsory school attendance—always providing that the scholar is receiving the object lessons of hygienic surroundings and practice during the whole of the school age.

I am disposed to believe that whereas from the very commencement of school life the object lessons of a sanitary environment should always be presented to the child, and he should be made to pay regard to the uses of the sanitary apparatus and provisions for his health and comfort, it would be a mistake to carry him beyond this until he reaches the age of twelve, except it be that certain sanitary precepts might figure in his copy books and reading primers. Having reached the age of twelve he should commence to receive definite instruction in domestic and personal hygiene. The teaching at this age must deal only with elementary and practical facts of importance, illustrated by the concrete where possible, and by object lessons, and these must be so clearly presented that they are understood and carry conviction. The teaching must deal with the most simple, the most easily understood, the cheapest and most practicable means of translating sanitary precepts into practice; not losing sight of the fact that it is the positive rather than the negative which must be presented to the scholar.

The conduct demanded of the scholar will constitute the moral training necessary, and the school buildings and fittings should, so far as possible, illustrate all necessary hygienic observances. It will be most valuable if, subsequent to school age at fourteen, those attending higher-grade schools or evening classes continue to have this important subject impressed upon them. But in the whole scheme of teaching hygiene the fact must never be lost sight of, that, from the broadest point of view, it is only the simple and essential laws of health that require to be taught, and that any scheme which aims at more than this will fail to realise the best results. I have found by considerable personal experience that it is most valuable in enabling the teacher to insure that he has been understood by those he is teaching, if, at the end of each of his practical lessons, he questions some of the pupils and invites questions from them. The aim, therefore, should be to instil these elementary principles of hygiene which relate to the person and the home.

The matters on which the children should be instructed are:—

The importance of and the way to secure—

(*a*) Fresh air.
(*b*) Cleanliness of surroundings.
(*c*) Cleanliness of person (body, teeth, hair).
(*d*) Cleanliness of habits (spitting, &c.).
(*e*) Bodily functions (regularity of bowels, &c.).
(*f*) Suitable clothing (sufficient protection, woollen garments next to skin, &c.).
(*g*) Food (clean utensils, protection from dust and dirt, &c.).
(*h*) Temperance in alcohol.

There is much to be said against the negative results of an education in which girls are largely separated from domestic influences and experience during the most impressionable years of life, and there is no doubt that the elementary facts of cooking and infant-rearing should be taught to every female child, and there should be a kitchen and a workroom in connection with every girls' department. Girls should therefore be taught in addition:—

(*i*) The selection of food (marketing and elementary cooking, the preparation of simple dishes by the simplest means).
(*j*) How to feed and manage babies.

This matter should be taught conversationally and in a homely way, avoiding all technical and scientific terms and illustrated by facts and objects which fall within the range of family life. As local conditions should to some extent determine the kind of instruction and advice given, the teaching should largely be impressed upon the scholars by local references, &c. For this and other reasons it seems undesirable to demand any book-learning of the scholar.

The child learns best from one of his school-teachers, who, moreover, has training and experience in teaching children; and these considerations, added to the fact that a special teacher for this subject is apt to exceed the simple requirements of the scholar, cause me to feel very strongly that the professional lecturer on hygiene should be excluded from schools, although he is a *sine quâ non* for teaching and training the teachers in training colleges, and perhaps for advanced pupils attending continuation classes.

Few things more impress themselves upon the scholar than when one of their number is singled out for some special duty. It would, therefore, be a most telling means to our end if one scholar in each class-room were constituted the sanitary monitor for the week. It would be his duty, during his week of office, to see that the ventilators were open, that the class-room was well flushed with fresh air upon every available opportunity, that cleanliness obtained, that dust did not accumulate, and that all sanitary requirements were observed in the use of sanitary conveniences provided.

There should also be more supervision and control over the scholars in the playground. They should not be allowed to run wild. More in the direction of character formation and moral training can be done by effective supervision and control in the playgrounds than in the class-room.

Special Articles.

EARLY HISTORY OF THE MEDICAL PROFESSION AND OF HOSPITALS.—III.

Regulations of the Hospitals in the Middle Ages.

Ordinarily, attendants and nurses, after a probation of definite time to test their abilities for this function, were required to dedicate themselves with spiritual vows, in order to exalt the dignity of the avocation, although hospital goods were administered by the more practical laity.

A rigid ordinance of the Brussels hospital interdicted access to its benefactions to any diseased person able to procure a livelihood by personal effort, or through the aid of others. The original and thoroughly religious character of these charitable asylums may be gathered from a requirement that each applicant should, similar to postulants of monastic chapters, solemnly confess and abandon his entire possessions. If the invalid was restored to health, he could withdraw and receive everything back again, and as a salutary concession it was ordained whatever remained over the costs and charges incident to medical care of such inmate, by testamentary disposition, might be willed at pleasure after death; but in case the person died intestate, the institution inherited his property to the exclusion of all heirs.

Identical with the Jerusalem hospital regulations of 1181 patients were to receive three times each week fresh meat, and if sanitary economy demanded, other food was freely provided. Women in pregnancy and foundlings were admitted, although under such scrutinising restrictions as tended to prevent the entrance of disreputable persons. In the Brussels hospital. entrants upon their reception formally donated earthly goods to the eleemosynary corporation in perpetuity, together with the legal rights which they had possessed, and professing an entire abjuration of civil society, assumed the clerical costume of brown or gray. No married person was admissible, and all trades or secular occupations were formally interdicted, and no one without imperative reasons was allowed to descend into the city. In the year 1341, an asylum partaking of the nature of an hospital was erected in London, for impoverished and aged goldsmiths, out of the public moneys and by charity.

Leprosy.

Of all afflictions entailing the severest misery during the Middle Ages, and necessitating a sagacious economy, both of medicine and legislation, leprosy was pre-eminently the worst. This dread disease, in its worst form, was fully known to professors of the curative art in the last days of declining Rome, and recognised as difficult of treatment. From the application of simple cosmetics to heal cutaneous discolouration preceding graver types of this disintegrating infirmity, to severer methods of emasculation, the entire range of medicaments and surgery was unsuccessfully attempted. The foundation of this abhorrent treatment appears to have originated in a professional asseveration that eunuchs and women were exempt from the disease—a notion maintained by the Arabic scholar, Athelard, in the twelfth century. Although leprosy seemingly assumed not the importance of an infectious disorder, nor became sufficiently extended among the nations of Western Europe to merit serious attempts at repression prior to the vast movement eastward and the reflex action of the Crusades, there can be no doubt of its existence in an aggravated form, dormant or confined to isolated invalids in the Occident, long before the middle of the eleventh century. Legislative enactments in the year 757, by Pepin, Frankish ruler, forbidding by rescript conjugal relations between a leper and a healthy woman, and the enforcement by Charlemagne thirty years later of sequestration against this terrible malady, interdicting contact with robust people, attest the full knowledge and dread of this disease among the early Teutonic races.

Crusaders, unquestionably provoked contagious diseases, on account of which the Levant for ages had been celebrated. Some of these were mainly generated in the West by infected vessels, dissolute armies, filthy bands of pilgrims, returning from the Orient. Leprosy, with other malignant disorders, engendered by unchecked licence, excessive indifference to sanitary rules, and almost total indifference to civil precautions, was spread throughout Europe as a vast epidemic anterior to the year 1179, to the rapid extension of which the criminal use by several of the same baths, when publicly established in the West, largely contributed. In some portions of Europe, however, medical practitioners, freely advised bacon as a sovereign remedy against the disease of leprosy, when, indeed, paupers were exposed to infection from tainted bathing water used by lepers, and at a time when bleeding and use of the bath, as anciently prescribed, were rendered doubly dangerous by common diet of pork, urged as infallible cures. In general, this excellent sanitary system of bodily lotion was regarded graciously by mediæval chroniclists. The waters near Naples, mineral springs at Bath, England, and at Arles, which cured gout, were especially famous. Frederick I. of Germany freely adopted this remedy by advice of his surgeons. It was apparently inevitable to prevent serious results from repeated use of identical water by filthy vagrants and leprous bathers which, combined with greed for pork as a standard diet, aggravated the types of epidermic eruptions. This meat was regarded by pilgrims as a great delicacy in their distressed famishing peregrinations to Palestine, and a mediæval romancer relates, with gleeful melody, how Richard the Lion-hearted, demanded bacon when prostrated with fever in the East, and in the absence of the real was given a generous cut of a boiled Saracen. Upon discovering the substitution he admitted that Turkish flesh was of finer flavour than swine. Mediæval annalists show the presence of this infirmity among the higher clergy and prelates, long anterior to its alleged introduction from the Orient.

Isolated houses, distant from the abodes and settlements of men, remote from highways of travel, were constructed to receive pestifers and inoculates, obliged to repair thither voluntarily or by force. In the year 1179, the third Lateran Council decreed that lepers should have private chapels and cemeteries, although the City of London, as early as the year 1118, established a Leprosarium for absolute sequestration of such patients. Knights of the Order of St. John, in the different countries of Europe, had consigned to their care and especial attention eighteen thousand lepers. These infects were forbidden entrance to towns and villages, and required to avoid possible contact with the healthy for fear of propagating the hideous malady; and to make such rule efficient they were obliged to carry a bell to sound an alarm upon the approach of travellers. Quarantine, in modern times, doubtless is executed upon more exact principles of science; but it has never been as inflexibly maintained, both by civil and canonical law as during the Middle Ages. Churches and cemeteries were formally set aside for exclusive use of these afflicted beings, and to the world of life and happiness around them they were as thoroughly dead as though sheltered beneath an eternal tomb. In the time of Louis VIII. of France, this disease had made such rapid progress in its sinister movements that at his death, in the year 1225, he bequeathed a sum of money to each of the 2,000 lazarettos in actual existence in his kingdom at this period—a figure still undiminished at the middle of the fifteenth century.

Other Pestilences.

Disregard of sanitary rules, woollen clothing perhaps, and a limited supply of linen vestments worn by the mediæval populace, prelates and beggars, dwellings of defective construction, doubtless aided in propagating the frightful calamities of pestilence. A more malignant cause was the arrangement of private houses and public structures, alike erected upon the principle of resisting armed aggression and successfully defending them through prolonged sieges. In these, contiguous to the principal edifice and part of it, were immense reservoirs constantly filled with water, and magazines stored with provisions. This fluid, after the lapse of time under confinement, reached absolute putrefaction; and when the germs of disease began to spread among the countries of Europe, its progress was accelerated by such filth which developed these seeds into pestilential bloom. Under the stress of defective regulations it was impossible systematically to bury the rapidly increasing dead, or prevent infection. In the sixth century, when a frightful pustular malady racked with mortality the metropolis of the Eastern Empire, destroying nearly ten thousand citizens daily, none could be found willing to bury or cremate decaying bodies. At intervals during the Middle Ages, with greater or less frequency, maladies of mortal infection suddenly appeared, against which medical and sanitary knowledge of the time was utterly impotent.

France.

[From our own Correspondent.]

Paris, September 2nd, 1905.

The Therapeutics of Collargol.

Since Credé, of Dresden, introduced in 1897 colloidal silver into therapeutics, the applications of the drug have been varied as well as numerous. It is used sometimes as an ointment (15 per cent.) or injected into the veins in solution (5 per cent.) at the dose of one drachm for the adult, and half that amount for children. It has also been given in pills ($^1/_5$ to ½ gr.), in a mixture (2 to 6 grs. in the twenty-four hours), and as a suppository (2 to 6 grs.). Dr. Breton of Dijon, who has made a study of collargol, publishes a series of cases in which the drug formed the principal treatment.

Erysipelas of the Face.

Several cases of this affection were treated by applications of an ointment of collargol at 15 per cent., and the result was very rapid without any complication.

The dermatitis was immediately arrested and fever fell suddenly. All the patients made a rapid recovery.

TYPHOID FEVER.

Two cases of the gravest form, death being imminent, were treated by injection into the veins of a 2 per cent. solution. The injections were repeated daily at the dose of one drachm. Both patients recovered against all hope, baths, injections of lemon, cafeine, camphorated oil having been tried with no improvement.

PUERPERAL INFECTION.

Four cases of puerperal fever of a very grave type were treated by extensive frictions of the ointment (15 per cent.) over the hypogastric region, while the uterus was swept out twice daily with absorbent wool covered with the same ointment. All the patients made a good recovery.

PHLEBITIS.

All the cases of phlebitis that came under his notice were treated by rubbing the whole of the limb with collargol ointment and afterwards enveloping it in cotton wool. Fever was never very high and resolution took place in from 15 to 18 days.

PHTHISIS.

Dr. Breton tried collargol in pulmonary tuberculosis The patients were in the third stage of the disease, with large vomicæ. Intravenous injections were made and under their influence the temperature lowered, the sweats diminished, the appetite returned, and the general condition improved. Naturally this remission in all those symptoms was only temporary, but life was prolonged for a certain time.

ABSCESS OF TUBERCULOUS GANGLIA.

Several young girls suffering from cervical tuberculous ganglia were treated by injections of a 2 per cent. solution of collargol into the glands. By means of a Pravaz syringe the pus was removed as completely as possible. Then, without withdrawing the needle, the solution was injected until it had filled the cavity, after a few moments a part of the liquid was withdrawn as well as the needle, and the small aperture sealed up with collodion. Every four or five days the injections were repeated, and in a short time the ganglion had disappeared, while—an important point in such cases—no trace of the operation could be observed.

VESICAL INJECTION.

A man, æt. 82, had suffered for a long time from urinary trouble due to hypertrophy of the prostate and for which he was obliged to use the catheter twice a day. The patient when seen by M. Breton was cachectic, feverish, without appetite, and each time he passed the catheter he drew off purulent urine. The bladder had become so irritable that irrigation with simple boiled water was very painful. A weak solution of collargol (¼ per cent.) was injected morning and evening, and soon the suppuration ceased. The patient regained his strength and appears as well as a man of his advanced age could expect. The urine is clear and abundant.

DIGESTIVE TRACT.

One-grain pills of collargol given three or four times a day were found very beneficial in certain gastric febrile affections, and especially in attacks of mucomembraneous enteritis.

VOMITING IN INFANTS.

Citrate of soda, 1 drachm.
Water, 10 ozs.
A teaspoonful before feeding.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, September 2nd, 1905.

DR. FRANZ HERZOG (*D. Arch. f. Kl. Med.*, 83, 102) relates a case of

TRAUMATIC PARALYSIS CAUSED BY PARTURITION.

A servant-girl æt. 19 was admitted into the Lying-in Klinik, on December 12th. Examination showed a generally contracted flat rachitic pelvis. The labour lasted thirty-five hours, and it was terminated by expression, as the fœtal heart-beats were becoming rhythmical. On the fifth day after labour a cephalhæmatoma was observed on the right parietal bone of the infant. There was no fever; on the fifth day the patient complained for the first time after the confinement that she could not move her left leg.

On January 4th she was transferred to the "nerve klinik," when she remarked that even when she was in labour on December 12th she could not move her left foot, that it felt numb, but not painful. She could not flex the foot backwards, and the plantar reflex on that side was less than on the sound one. Supination of the foot could be performed but pronation was limited. The movements of the toes were also imperfect, they could not be extended.

After four months the flexor of the leg had caused moderate contracture in consequence of which passive dorsal flexion of the foot was possible only to the extent of the sole forming a right angle with the leg. There was also slight atrophy of the paralysed muscles. In walking the left foot was raised higher than the right, and the act was very difficult. The patellar reflexes were alike on both sides. The right Achilles tendon reflex was present, the left not; plantar reflexes absent on both sides. As regarded disturbance of sensation there was anæsthesia only at the second and third left toes and it extended from the toes to the adjoining part on the back of the foot. The first, fourth, and fifth toes and the distal half of the dorsum of the foot were hypæsthetic.

The patient left the hospital on June 28th, and she could then walk almost without limping; but this was through education of healthy parts rather than from any real improvement in the condition. The left Achilles tendon reflex was still absent.

In traumatic paralysis of this kind (caused by the labour) it was characteristic that the pains or numbness were felt in the limb during labour; that the paralysis was discovered either during labour or shortly afterwards; that it was limited mainly to the peroneal nerve and that the course was tedious and that much improvement or complete recovery was only rare.

The paralysis was attributed to injury to the pelvic nerves from pressure when the relations as to size between the pelvis and the fœtal head were unfavourable. The fibres of the peroneal nerve sprang from the lumbar spine and joined the sacral plexus through the lumbo-sacral trunk. This ran diagonally across over the linea terminalis whilst the sacral plexus occupied a protected situation. The lumbo-sacral trunk principally contained fibre for the extensor muscles of the lower part of the leg and the peronei muscles, and besides these only such as played but a small part in the innervation of the flexor muscles. Injury to the lumbo-sacral trunk must always result; therefore the paralysis of the peroneal region, may also affect in a lesser degree the tibial and gluteal regions. In the present case the only sign that the tibial nerve was affected was the absence of the Achilles tendon reflex.

In the majority of such cases of paralysis forceps were employed and in all the labour had been lingering. In the writer's opinion there was no causal connection between the use of forceps and the paralysis, it was the prolonged pressure of the head and nothing more that did the mischief. Possibly alcohol, syphilis, or the gravidity itself might be contributory causes.

The course of the paralysis was always lingering, and its prognosis not good; of 30 cases, 4 recovered, 11 improved considerably, and the paralysis persisted in 15.

A TRADE INSURANCE CASE.

Dr. Becker Kreisarzt von Hildesheim, reports an interesting case in the *Aerzt. Sachverstarn Zeit.*, The case was one of sudden death. A man, æt. 65, whilst at work, fell on to a wheelbarrow and hurt himself at the root of the nose and over the eyebrows. At first he went on working, but very shortly severe dyspnœa came on and he got worse, whilst he was being taken to a doctor. About two hours after the accident, and just as he was being taken into a hospital he died. The autopsy showed no injury to the stem of the neck, no abnormal signs about the muscles, nerves, or great vessels of the neck; but on the other hand a plug of chewing tobacco, 4 cm. in length and 1 cm. in diameter was found lying between the root of the tongue and the epiglottis, there was also swelling of the uvula, strong injection of the fine vessels of the mucous membrane with blood at that spot; swelling and discolouration of the mucous membrane at the entrance of the larynx and dark blue discolouration of the mucous membrane of the fauces, caused by extravasation of blood into the tissues, similar extravasation under the mucous covering of the larynx and of the upper part of the trachea. The cause of death was given as suffocation from a piece of tobacco.

As the widow made application for an allowance from the trade society, the case was gone into more thoroughly. It was proved by witnesses that the deceased had stated that he fell on his larynx (mit den Kehlkopf) and further that a quarter to half an hour later he spat blood and could scarcely speak. The writer being required to give an expert opinion on the matter on behalf of the Imperial Insurance Office, gave the following—that there were two possibilities of a causal connection between the accident and the death.

First, it was quite possible that at the moment when the accident occurred the plug of tobacco in the man's mouth was forced into the œsophagus, that it could not be got up and that it caused death by gradual and intensifying suffocation.

Secondly, the swelling of the soft parts might be directly attributed to the accident and the fact that there was no skin wound was not against such an assumption as that the necktie, collar, &c., might have warded off the sharp force of the blow, or the blow might have driven the larynx violently against the bodies of the cervical vertebræ, whereby lacerations of the vascular network of blood-vessels were caused at the spot.

In the latter case the plug of tobacco would be of no importance and it might be assumed with probability that it got into the deeper part by handling after death.

The Imperial Insurance Office took this view of the case and decided in favour of the widow and ordered the trade society to pay the death money to which she would be entitled and also the pension.

Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, September 2nd, 1905.

Vaporin.

This is a mixture Prof. Monti has been using on the children of the "Poliklinik," with reputed success in pertussis and is much praised by other observers. It is composed of the following:—

Naphthalin, 180 grammes.
Camphor ras, 20 grammes.
Olei eucalypt. glob. piceæ, 3 grammes.

This is put in boiling water and the room in which the child is located saturated with the vapour. This is reported to give immediate relief.

New Drugs.

At the Medical Association in Prague, Chodounsky warned practitioners against the use of every drug that was launched on the market nowadays. as many of them were not what they were represented to be. He knew he was "fighting up stream" when he attacked this mania, but he felt it his duty to warn his fellow practitioners against the free use of drugs whose physiological properties were indifferently known.

If the physiological action be unknown let him beware of the toxicological effects.

The Larynx in Paralysis Agitans.

Cisler reported on 14 cases of paralysis agitans, and noticed a condition of the vocal cords not recorded by any other author in eight of them. One or both of the vocal chords were found in or near the middle line or cadaveric position. In his argument on the cause of the phenomenon he came to the conclusion that the rigidity of the muscles of the larynx overpowered the vocal chords and thus produced the morbid condition met with.

Cæsarian Section.

Ostreil gave the members of the Association a strange reason for performing the Cæsarian section. The patient had previously had two children, one of them five years ago causing rupture of the uterus with subsequent puerperal conditions and hæmorrhage, which curettage corrected.

On the present occasion Ostreil tells us that the pains commenced but no opening of the uterus took place owing to the soldering of the os. He relieved this atresia, but could not get more dilatation of the uterus than half-a-crown in area. He finally resolved to operate, and performed the Cæsarian section with success to mother and child both of whom are now well.

At the same time he related the history of an extra uterine conception which he operated on with equal success. It was her third confinement, she had great pain and fainting during the pregnancy and nothing in the uterus, though the movement of the child was visible. Laparotomy was performed and the child found in a sac behind the uterus. Drainage into the uterus completed the recovery. The pregnancy seemed to be either ampullar or tubo-ovarian.

Hæmo-Volume Meter.

Hynck showed the members how Grawitz's volumemeter could be used for macroscopic diagnosis. He fills the capillary end of the tube with a solution of the oxalate of soda; draws the blood through it which is partially absorbed. The capillary is next sealed with wax and the blood allowed to settle. On the top of the salt the erythrocytes collect, over these the leucocytes, and over all the blood plasma. In normal blood the thin layer of leucocytes over the erythrocytes will be only a line, whereas in leucocythæmia it may cover a wide space. The colour of the plasma is of little value, although the quantity of the erythrocytes may be a guide in many morbid conditions.

Sinuitis Frontalis.

Honl related the case of a boy, æt. 13, who came to the clinic with a record of meningitis acuta. The frontal sinus was filled with a thick yellow pus and proceeding further with the operation the outer surface of the dura mater in the frontal region was covered with a thick green pus, a litre of which was drawn from the sub-dural space. This pus contained a large number of Pfeiffer's influenza bacilli. The presumption is that the infection from the nose reached the sinus frontalis and thence passed by the sulcus ethmoidalis into the dura mater, where the destruction took place.

Rontgen Rays and Leucocythæmia.

Hynck recorded a series of six cases of leucocythæmia which he had treated successfully with Röntgen rays. In every case both subjective and objective symptoms began to disappear as the treatment advanced, but it may be noted that arsenic and phosphoric acid were prescribed at the same time. He finds that those treated in this manner do not recur so readily as those treated by other means. All of them showed at different stages hyperglobulin with an increased number of erythrocytes.

Expiratory Pulse Retardation.

Vanysek criticised the three symptoms of the neurasthenic—viz., expiratory pulse retardation, and orthostatic tachycardia, and the Erb symptom. These three symptoms he said were associated with the centre that regulates the activity of the heart. They are not altogether confined to the neurasthenic, but are met with in convalescence from severe febrile diseases, acute and chronic poisoning such as phosphorus and sulphur and rapidly growing children. The tria cannot therefore be accepted as an infallible diagnostic

The Treatment of Hæmorrhoids.

Dr. Schlacht, who has given the subject long and careful study, has just issued a second edition of his work, "Die Chirurgische Behandlung der Hæmorrhoiden," like all zealous students in the pursuit of knowledge, complains bitterly of the absence of progress in the treatment of hæmorrhoids since the days of Hippocrates. From the beginning of the Christian era Schlacht tells us of many strange cures for this complaint, but not till 1897 are we acquainted with any change, when Reinbach put forward the theory that hæmorrhoids were a neoplasm of a benign character. The book is well written and can be recommended for its salutary investigation on a subject that has long lain in a state of quiescence. Schlacht closes with a feeling of sadness that so little has been accomplished to alleviate human suffering in such a common complaint.

Operating Theatres.

KING'S COLLEGE HOSPITAL.

Hernia of the Bladder.—Mr. Peyton Beale operated on a man, æt. about 30, who had been admitted suffering from what was apparently a right inguinal bubonocele. When the patient coughed the tumour was observed to be rather more rounded than usual, and of a much firmer consistency than is generally found in an ordinary hernia. Afrer an incision had been made just above the position of the external ring, the cord was as usual drawn up through the wound, and a large lipoma was found adherent to it. At this stage of the operation Mr. Beale remarked that he had observed that hernias of the bladder were very often associated with such a lipoma in connection with the cord. The lipoma was removed and no sac could be discovered. On investigating the inguinal canal it was found to contain an ovoid structure about the size of a walnut, the apex of this was very thin and apparently composed of loose strands of fibrous tissue, but the rest of the structure felt solid when squeezed between the fingers. When this body was pulled down it was seen to continue into the abdominal cavity in the form of a tube. Mr. Beale remarked that it was impossible to say what the structure was, but it certainly had not the appearance or consistency of any part of the bladder. While making traction on this body some of the loose fibres at its apex gave way, and this was followed by the escape of a small quantity of fluid; this disclosed a cavity lined with smooth mucous membrane. It was now evident that the body was a diverticulum of the bladder with hypertrophied walls nearly half an inch thick, but its apex to which the lipoma had been clearly attached was exceedingly thin, the attenuation having evidently been produced by the constant traction of the lipoma extending over a period of some years. The diagnosis was verified by the passage of a solid bougie along the urethra into the bladder. The bladder diverticulum was then ligatured off in the same manner as the mould of the sac is tied up, previous attempts at suturing the opening in it at its apex having failed owing to the thinning out of the structures forming its walls. The wound having been washed out, the inguinal canal was stitched up, leaving just sufficient room for the cord and its covering, and a small gauze drain. The skin wound was then sutured, a gauze drain being left protruding. Mr. Beale said that this was quite a usual condition met with in cases of hernia of the bladder, although these herniæ were much more common in women than in men. A diverticulum of the bladder appearing as a hernia very rarely, he pointed out, had the appearance of the normal bladder, and was commonly opened by the surgeon without his having any suspicion that it might be bladder. As a rule, no harm resulted from such opening providing the patient was not suffering from cystitis. The thinness of the wall at the apex of the diverticulum was, he thought, remarkable, and it was quite possible that this was due to its having undergone fatty degeneration.

ST. THOMAS'S HOSPITAL.

Two Cases of Torsion of an Ovarian Cyst.—Mr. Edred Corner operated on a girl, æt. 17, who had been admitted suffering from what was supposed to be appendicitis. She had had indigestion for some years. Seven months before admission she had an attack of pain in the right iliac fossa, which shot along the right thigh as far as the knee. She was then confined to bed for about a week. Three months before admission she had a similar attack, which lasted ten days. One month before admission, she had a third attack, which was more severe, attended with troublesome vomiting. This kept her in bed a fortnight. The pain was increased on passing water and on defæcation. Menstruation was irregular. On examination after admission there was pain and resistance in the right iliac fossa. *Per rectum*, a mass was felt high up on the right side of the pelvis. Operation was performed three days after admission. McBurney's incision was made over the appendix region. The appendix was long and slightly adherent to a cystic swelling in the pelvis. The appendix was clamped, ligatured, removed, and the stump inverted into the cæcum. The wound was sutured with fine silk. Another incision was made in the median line below the umbilicus in order to explore the cystic swelling in the pelvis. The cyst was about the size of a fist, and connected with the right ovary. When it was delivered it was found that the pedicle was twisted through one complete turn in a direction contrary to the hands of a watch. The cyst was removed and found to contain extravasated blood. The left ovary was also slightly cystic, but it was left. The wound was closed in the ordinary way by three layers. Mr. Corner said that this case was very interesting as illustrating the confusion that may occur between diseases of the appendix and those of the right ovary and uterine appendage. Clinically, he pointed out, the case presented all the features of an ordinary case of appendicitis, and disease of the right ovary was not found until the operation. The appendix, he remarked, was long and adherent to the cyst, so that the patient had undoubtedly suffered from appendicitis, but the twist found in the pedicle of the cyst and the blood which it contained pointed certainly to the cyst being the cause of the attacks of pain and probably also being the indirect cause of the appendicitis. Another feature, he said, was worthy of mention: The torsion of the pedicle of the cyst was not acute and the attacks of pain were undoubtedly due to increments of the twisting which temporarily occluded the vein, hence the extravasation of blood into the cyst; further, at the operation it was noted that the left ovary which was not removed was cystic and the size of a hen's egg.

The girl was seen three years later. She was in perfect health and on examination the disease in the left ovary had not progressed.

The second case was that of a nurse, æt. about 40, who was a chronic sufferer from indigestion, and for the last year had had attacks of pain in the right iliac fossa which had kept her in bed during the different attacks from three to fourteen days. Besides these severe attacks she found when helping her patients to change their position in bed that she had severe pain in the lower part of the abdomen which made her feel very sick and faint and necessitating her lying down for some minutes. On examination there was pain and resistance in the right iliac fossa. *Per vaginam* there was pain and tenderness high up in the right side of the pelvis. The case had been diagnosed as one of appendicitis. The abdomen was opened by displacement of the outer and lower part of the right rectus muscle. The appendix was found to be slightly adherent, but not grossly diseased. It was clamped, ligatured, and removed. A cyst about the size of a hen's egg was found in the right ovary, which, when it was delivered on to the surface of the abdomen, was seen to have a twisted pedicle, and to be full of blood. The cyst was removed and the abdominal wall sutured in the ordinary way. Mr. Corner said that this case was very similar to the one he had first operated upon. In both of them the histories and conditions found at the operations were almost identical. In both cases the primary cause of the trouble was sub-acute or chronic torsion of the pedicle of an ovarian cyst of the right side, which had secondarily caused inflammation of the peritoneum surrounding the appendix and appendicitis. This appendicitis was very different from ordinary cases of that disease for in ordinary cases the inflammation arises from the inside of the appendix, whilst in these two cases the inflammation arose from outside. In this second case, he said, there was one point to which particular attention should be drawn, namely, the sharp and sickening attacks of pain in the lower part of the abdomen, which occurred and recurred whenever any effort, such as lifting a patient, was made. This, he thought, was a point which might be of the greatest use in the diagnosis of future cases and in differentiating between inflammation and torsion of the pedicle in the region under consideration. These two cases emphasised, he considered, the extreme importance of examining the right ovary and appendages in every woman who is operated upon for appendicitis; such a step, he thought, should never be omitted.

Cholera Scare—Germany Alarmed at the Progress of the Disease.

Cholera in Germany appears to be steadily increasing. One death is reported from Hamburg, that of a Russian emigrant. In West Prussia there are now over sixty cases.

Medical Tour in France.

One hundred and fifty British, German, and Danish doctors, taking part in the seventh tour made for the purpose of medical study under the direction of Professor Landouzy, a Member of the Academy of Medicine, arrived at Bagneres-de-Luchon last Friday.

A fine hospital has been completed at Punta Arenas, a town in the most southerly department of Chile.

A general hospital, at a cost of 2,191,950 dollars, is in course of erection in the city of Mexico.

The Army Council has decided to cancel the order directing medical officers returning home at the end of a tour of service abroad to report themselves personally to the Director-General. These officers will in future report themselves to the War Office in writing.

Dr. A. Wynter Blyth, Medical Officer of Health of Marylebone, in a recent report concerning the health of the borough during July last, states that the death-rate was 12·3, against 16·9, the average in July for the preceding five years. This singularly low rate of mortality is attributed to sunny weather and freedom from epidemics.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, SEPTEMBER 6, 1905.

DROWNING AND ARTIFICIAL RESPIRATION.

The recent issue in book form of the Report of the Committee appointed by the Medico-Chirurgical Society to inquire into the "Phenomena attending Death by Drowning and the Means of Promoting Resuscitation in the apparently drowned," calls attention to some important points both in the mechanism of drowning and in the methods of artificial respiration. The Committee, of which Professor Schäfer was chairman, entered into the work with considerable zest, and performed a number of experiments on dogs and men with a view to elucidating the knowledge they were in seach of, yet one cannot but be disappointed in reading their report to find that from lack of time, means, or enthusiasm, they did not carry their researches to the point of definite and unchallengeable decision. The phenomena of drowning are still far from being properly understood, and much of the information found in text-books on forensic medicine having been culled solely from post-mortems on drowned bodies is far from satisfactory. There are few medico-legal decisions of greater difficulty than that of saying definitely whether a given body found in a river or in the sea came to its death by drowning or was thrown into the water after death; the point is continually arising in coroners' inquisitions, and it must be admitted that owing to uncertainty as to the signs of drowning, the medical witness is not always in a position to give a categorical opinion. Now it is obvious to anyone who has performed many post-mortems on drowned persons that drowning is far from being a simple, straightforward act. Some persons "go down like a stone"; others gasp and struggle for many minutes. Naturally the post-mortem appearances corresponding to the conditions are vastly different. The Medico-Chirurgical

Committee adopted such artificial methods of drowning the dogs on which they experimented that the conclusions can have but a partial application to the phenomena of drowning in general. The dogs were anæsthetised and their muzzles held under water, conditions necessary enough in obtaining respiratory and blood-pressure tracings, but hardly comparable to those which obtain in reality. Still, some important facts were brought to light. One of the most striking is that drowning in fresh water appears to differ from drowning in sea water in certain particulars. The experimenters were struck by the fact that most of the water inhaled during drowning was found to have disappeared when the post-mortem came to be performed, and the amount of the water taken in was found to be no measure of the rapidity or certainty of death. Respiration at the first shock was suspended, then became violently expiratory, and not until the last stage were deep inspirations taken. Now this water thus inhaled was found to pass rapidly into the blood, so that in only one case did the lungs after death show any increase in specific gravity, and little or no water exuded from the lungs when they were cut into. With sea-water, however, it was found that the quantity of water absorbed into the blood from the lungs was less than in the case of fresh, owing probably to the osmotic force of sea-water being higher than the blood. Another fact elicited was that the amount of froth found in the air passages after drowning in sea-water was greater than after drowning in fresh, but on the other hand this froth was more fluid in consistence when mixed with the former. Thirdly, immersion in sea-water appeared to be less rapid and certainly less fatal than in fresh. In fact, not only was it easier to re-establish respiration after salt-water immersion, but in two instances the animals recovered completely in quite a short time, and seemed but little the worse for their experiences. We now turn to the time during which immersion may last and yet be followed by recovery, and here we find that contrary to certain statements that have been made lately, immersion may last for several minutes (in one case it lasted nearly eight minutes) and yet not prove fatal if artificial respiration be adequately performed after extraction from the water. Early death was found to be due to cardiac failure and was preceded by a rapid fall in blood-pressure, but if the animal outlived this danger it could be saved by artificial respiration, provided that the air could be made to reach the alveoli and through the alveoli the blood. The chief barrier to the entrance and diffusion of air was found to be frothy mucus. This is not necessarily proportionate to the length of submersion, but seems to depend rather on the quantity of mucus secreted and the amount of convulsive respiration that takes place and churns the mucus up into froth. Such froth is more difficult to get rid of when found in the smaller tubes, and consequently the danger of asphyxia is greater under those circumstances. Moreover, the longer recovery from respiratory obstruction is delayed, the greater is the danger of cardiac failure. From these observations it follows that much of the success of artificial respiration turns on the method employed and manner by which it is carried out, and the Committee made a study of these questions also. They began by renewing the experiments made by the 1862 Committee, which investigated the same subject, that is to say, they performed the movements of artificial respiration on cadavers and measured the amount of air that entered and left the chest. But they soon found this plan highly unsatisfactory, first, because of the difficulty of getting healthy subjects, and, secondly, because of rigor mortis limiting the extent of the movements. In the end they decided to carry out their trials on the living subjects, and to measure the quantity of air exchanged by means of a spirometer. A young man was trained for the purpose—and a trial—not a very exhaustive one it seems—was given to all the known processes of performing artificial respiration. Taking the amount of air pumped during normal respiration as 455 c.c. per respiration and 5,850 c.c. per minute, the Committee found that the Silvester method gave 178 c.c. and 2,280 c.c. respectively, the Marshall Hall 254 c.c. and 3,300 c.c. the Howard 295 c.c. and 4,020 c.c., and that the intermittent pressureover the lower ribs in the prone position was 520 c.c. and 6,760 c.c. Although other factors than mere exchange of air enter into the utility of a method of artificial respiration,the Committee seems satisfied that not only does the last-named ensure the largest exchange, but that it has other advantages which should bring it into more general favour. In using Howard's method there seems to be a distinct danger of rupturing the liver, which is naturally much congested and enlarged in asphyxial conditions.

DEFENDED LAW AND DEFENCELESS MEDICINE.

THE unprotected rights of medical men have long formed a standing complaint in the journals specially devoted to the affairs of that learned profession. In various ways the subject is of national importance, for it strikes deep into the essential well-being of the people. The principle involved is nothing less than the preservation of the health of the nation, first by the provision of duly qualified medical men, and, secondly, by the exclusion of unqualified and therefore dangerous and illegal practitioners of medicine, otherwise quacks and charlatans. The first of the two aims has been amply accomplished by the Medical Acts, administered by the machinery of the General Medical Council. It may be asserted without fear of contradiction that the general standard of medical education and attainment was never at a higher pitch than at the present time. It is, of course, possible that educational methods may in the future undergo a material alteration and that the consolidation or even unification of medical qualifications may ultimately prevail, but on the whole the existing state of affairs with regard to the safeguarding of the public against incompetent medical practitioners may be regarded as satisfactory. A similar thing, however, cannot be said when we turn to the second of our propositions, and ask whether the community is reasonably protected by the Medical Acts against the evil practices of irregular medical practitioners. There can be but one answer, and that is to be found writ large in the advertisement columns of the lay press. Every conceivable disease from which humanity can suffer may be cured by some proprietary nostrum or by some irregular practitioner or other. These parasites run the gamut of medical and surgical practice, from freckles and eczema to Bright's disease, from electrolysis to such grave surgical procedures as the cure of ruptures, the treatment of fractures and dislocations, and plastic operations about the face. Yet there is none to say them nay, unless their nefarious practices land them in the police court. By gross elementary defects in the Medical Acts no effectual powers are granted for the prosecution of illegal medical practice. Nor is the duty imposed upon the General Medical Council. As readers know, the only available method of procedure against quacks is by a special section of the Apothecaries' Act. The conditions attached thereto, however, are easily evaded. It is quite possible, nevertheless, were the police alive to the necessities of the situation, that a great amount of irregular medical practice might be suppressed by the operations of the ordinary criminal law applying to conspiracy, false pretences, and vagabondage. If the police want to rid a neighbourhood of undesirable persons they can apprehend them for "sleeping out," for having no visible means of subsistence, for loitering and for various other more or less artificial and doubtful offences. Surely the police could find some means of ridding the community of the host of quacks who live upon the misfortunes of their fellows. The police, however, are not likely to take action while medical men treat the protection of their own vital interests with undisguised apathy. A lesson might well be taken from the lawyers, who do nothing by halves when the legal protection of their profession is concerned. The slightest infraction of ordinary legal practice is visited with instant prosecution and heavy penalties. Indeed, so stringent is the protection that a solicitor is not permitted to act without taking out every twelve months a licence to practise. The principle of yearly certificate goes to the root of the matter by insisting on the necessity of regulating and registering properly qualified solicitors as a first step. Only a few days ago a solicitor was fined £31 7s. for practising without having taken out his annual licence. Contrast that state of affairs with the laxity that permits disqualified medical men to continue practice with impunity and to flaunt that fact in advertisements inserted in the daily newspapers. There is much to say in favour of the yearly licensing of all qualified practitioners. It would confer a reality upon the present imperfect control of the *Register* in the hands of the General Medical Council. As a preliminary step it mould be necessary to render registration of qualified medical men compulsory instead of permissive. There can be little doubt that this would be one of the readiest means of providing a sufficient income to the General Medical Council. This change, as a matter of fact, should be one of the earliest of the many reforms needed to put the medical profession in possession of what is nothing more than its just and reasonable heritage, not to mention the enormous national advantage of the legal regulation and protection of medical service throughout the State.

Notes on Current Topics.

The Profits of Milk Adulteration.

The practice of food adulteration is not likely to be seriously curtailed under existing conditions of detection and punishment. As in the case of betting prosecutions the profits of the calling are so large that the payment of frequent fines is a mere fleabite to the offender. Especially is this true of the adulteration of milk, inasmuch as the fraudulent vendor is actually selling water to his customers at the price of milk. Could that method be extended indefinitely it would result in riches beyond the dreams of avarice. Fortunately, however, the bounds are set in the shape of Food and Drugs inspectors and of police-court prosecutions. Some of the most cruel and heartless of these malpractices are inflicted upon poor law consumers. Last week a man named Judge was convicted at the West Ham police-court of having sold adulterated milk to the local union. He was under contract to supply "genuine unskimmed milk" to the extent of one hundred and forty-eight thousand gallons at 9½d. per gallon. Analysis showed that the milk delivered at the union contained 32 parts per cent. of added water. A simple sum shows that the profit of water sold as milk in this transaction would amount to some £1,800 or £1,900. Well might Martin Judge, of Plaistow, smile as he paid the £5 fine and 14s. costs inflicted by the magistrate. The only adequate punishment would be to make such an offender pay several times over the cost of the damage inflicted in such a breach of contract, and to make imprisonment compulsory after a first offence.

Seaside for Children.

In his interesting and suggestive Presidential Address at the Sanitary Inspectors' Association, Sir James Crichton-Browne drew attention to the evils of town-life, and pointed out the fallacy which lay in the argument that by concentrating the population in towns, capable men were brought to the front. If there were any truth in the contention, such production was at the expense of their physical stamina, and probably of their intellectual, too. In providing educational ladders for the people, the rewards went to the precocious and quick-witted, whose energies in many instances rapidly exhausted, whilst children of greater power but of slower development were left at the bottom. The real breeding-ground for the race is in the free and natural liberty of the country, and if the best stock is continually drafted into the towns, sooner or later an inferior product alone will be left for the jaded and unfertile townsfolk to draw upon for recruits. For those compulsorily located in towns a sanitary country cottage is the most healthful and restful holiday resort, and for children dwelling in London and populous towns some such change is especially needful. Sir James pointed out the banefulness of the fashionable idea that children in the summer should be taken from an inland town to a seaside one, there to re-enact under similar but slightly changed conditions much the same artificial life as that which they have left. Children, of course, are notoriously impressionable, and they rapidly fall in with the idea that a holiday is a time to be spent in watching nigger-entertainments on the sands, or listening to bands on parades or piers. The holiday provides for the town-child its only real opportunity of acquiring any knowledge of or association with the pleasures of Nature ; but for most of them, when the habits of plants and animals, the beauties of flowers, and the secrets of birds and insects might not only be charming, but educating them, their time is prostituted with a round of unhealthy excitements. Real health is to be found not in assimilating the conditions of the holiday to those of the town, but in making them as different as possible.

Soap for Paupers.

THE cleansing action of soap has been known since the far-off days of Pliny. It is interesting to trace the evolution of the art of soap-making through the earlier centuries to the present day, in which latter the manufacture of toilet-soap has become almost a fine art. Happily for those of small means, the efficacy of soap is in no way controlled by its price, for there is nothing like common soft soap for thoroughly emulsifying and carrying away surface dirt. Nevertheless, in spite of the cheapness of soap generally, recruits are not found wanting to join the great army of the unwashed, which has by no means yet become disbanded. The list of preventable diseases caused by neglect, wilful or otherwise, of the first principle of health, cleanliness, is a long one. Practically all the parasitic affections of the skin would be prevented by the regular application of soap and water, which fact impresses itself most forcibly upon those whose duty it is to see and examine large numbers of the poorer classes in the out-patient departments of our great hospitals. Only a minute percentage of these individuals are really unable to afford one penny for a cake of soap. In the majority of cases their condition is due rather to neglect and indifference than to poverty. If the pauper will not or cannot get soap for himself, then the soap must be brought to him, and we think that the action of the Strand Union Board of Guardians in giving half a bar of soap to every pauper in receipt of outdoor relief worthy of emulation. There is no necessity, of course, for providing scented soap, for a sickly odour of roses does not make a cake of soap more effective, and we confess we are a little surprised to see that another board of guardians has decided, upon the recommendation of the lady doctor in charge, to supply the children in the workhouse schools with *sixpenny* tablets of scented soap instead of the common article. What will the ratepayers say ?

Evolution v. Physical Deterioration.

THE much-discussed question of "physical deterioration" has, as of course every reading (and hearing) member of the community knows, recently engrossed a large proportion of the attention of many of our most representative thinkers. It has turned the eyes of the curious and the patriotic towards the sources of enlightenment and assumed revelation offered by the up-to-date editions (and manifold modifications) of the theories of evolution, of natural selection, of survival of the fittest (or unfittest), of heredity, of the influence of environment, of racial character and configuration, and—not to worry the reader further while attempting to hunt the scientific phrase to death—of sunshine and cutaneous pigmentation. One scientific logician contends that, as in the language of the famous clerical poet, "Life's cares are all comforts"—the presence of adverse conditions, in slum life and other, is after all but a blessing in disguise ; for it tends to maintain the continuity of the *struggle* which merely calls forth the *actual* powers of the normal hereditary *potentialities* of the individual. According to this twentieth-century edition of optimism, if all such adverse conditions were successfully eliminated by the combined efforts of the philanthropic legislator and the scientific sanitarian, the race would progressively degenerate, and grow less and less resistant to the attacks of disease. In this connection it has been suggested that the chief function of bi-parental reproduction is to maintain the characters which have been fixed by natural selection. The germ cells must possess the most providential capabilities of resisting external influences. Had it not been for the existence of this biological "fact," those groups of germ cells which tended least to degenerate would survive, while those that tended to lapse into the abysm of degeneration would necessarily be soon eliminated. Evolution of the power to resist retrogression in such characters as have been fixed by natural selection started, we are assured, with evolution itself ; and this fact undoubtedly accounts for the extreme resisting power of the germ cells which recent biologists have commented upon. It is admitted that if families continue the struggle of slum existence, they are inevitably eliminated in the course of three generations at the furthest. Those only survive who possess the character and will to work their way quickly out of slum life. And the all-important evolution which has brought man up to his present position, is one of character, of intellect, of moral forces, and of the habits which are consonant with the needs of social life. Evolutionary resistance to disease and alcohol has taken a very secondary, perhaps a negligible part. We only wonder after the contemplation of such exceptional scientific attainment and philosophic contemplation, what proportion of such statements and arguments could be reduced to syllogistic form!

Food Adulteration.

Among the many questions which have recently been brought into public prominence by the re-echoing boom of physical deterioration, is, as a naturally consecutive consequence, that of the food of the labouring classes. The standard of comfort in the home life of the working man has very notably risen of recent years; he and the various members of his family are provided with food of greater variety—larger in quantity, better in quality, and (professedly) more digestible—than were his parents of the past generation. Agricultural labourers then thought themselves fortunate in securing one meat dinner per week. Yet we are assured that our population is degenerating physically all this time! Nature, we know, performs many apparent absurdities, as the history of every age has shown; and would sometimes almost tempt us to think that she occasionally wishes to lower the overweening conceit of man by placing within stimulating range of his vain curiosity certain interesting, and even important problems which his Tantalus-efforts fail to solve. One of the causes suggested to account for our physical deterioration is that what people used to eat in the bygone days was at any rate what it professed to be, while the canned, tinned, potted, and preserved foods of the present day are usually compounded—at least in considerable part—of various somethings a good deal less nourishing than their outlying labels would lead the confiding consumers to believe. A goodly proportion of the tinned foods consumed in England comes, of course, from the great Western Republic, and a somewhat lurid light has just recently been thrown on this subject by a bulletin issued by the State Board of Health of New Hampshire. The publication of this document must be distinctly disconcerting to the digestive memories of readers who have been indulging in the convenient luxury of manufactured foods, for we there find it stated that of the specimens examined, 91 per cent, of the canned fruits, jellies, and jams were adulterated; every sample of lime-juice was adulterated; so were 56 per cent. of the meat products, pressed meats and sausages; 50 per cent, of the cheeses; and, in general, of 363 samples of food-products scientifically examined no less than 164—or 45 per cent., were found to be liberally adulterated, or widely divergent from the legal standard. In presence of such data the problem of physical deterioration is hardly so very mysterious after all!

A New Anæsthetic.

Though the introduction of chloroform and ether marked one of the greatest and most beneficent revolutions in surgery, there are few surgeons whose hearts will not be gladdened when they are relegated to the limbo of forgotten things, and some simpler, safer, and less distressing drugs take their place. The pharmaceutical field has been carefully searched for new anæsthetics, but in spite of certain agents of minor utility, such as ethyl-chloride, having been unearthed, chloroform and ether are far from being superseded. It seems, however, that scopolamine, an alkaloid of scopola, which has hitherto been known as a mydriatic and sedative, can be usefully employed for general anæsthesia. Terrier, of Paris, reports that it can be given, preferably in association with morphia, so as to produce insensibility lasting as long as nine hours. The patient during this time appears to be in a profound sleep, but though he can be roused by shaking and shouting, complete insensibility to pain exists. When the effect wears off he wakes as from sleep, has no knowledge of what has occurred—even if an operation has been performed in the interim—and is free from all adverse symptoms. The appetite is unimpaired, and he can enjoy food. The best method of administration is by hypdermic injection—in combination with morphia. One milligramme is injected with a centigramme of morphia four hours before the operation, another similar injection is given two hours later, and a third after one hour more. The only drawback to this ideal method of inducing anæsthesia is that the drug is not always successful, and profuse sweating sometimes follows its use. If these disadvantages could be obviated, scopolamine would seem to have a rare future before it.

Suprarenal Therapeutics.

The introduction of extracts of the suprarenal glands into the treatment of disease has given the profession a vaso-constrictor which has practically superseded all others. It seems, however, that whereas all preparations of the adrenal bodies are made from the entire gland, the cortical and medullary portions are as different in function and secretion as they are in structure. Vassale and Zanfrognini, two Italian physiologists, have attempted to discover the effect of ablation of the medullary portion of the gland. Using cats for their experiments, they found that such removal led to death with symptoms suggesting that an essential substance had been withdrawn from the economy. This substance would seem to be the secretion of the medulla which they conclude acts as a stimulant leading to contraction of the unstriped muscle, and also as a ferment regulating certain clinical changes that prevent auto-intoxication. Vassale later was able to show not only that the substance extracted from the medulla of the gland was five times as potent as that from the cortex, but that it exerted a powerful contracting influence over the smooth muscle of the alimentary tract. As the substance is not affected by the gastric secretions, it can be given by the mouth, and in Vassale's hands has proved of great service in the treatment of the atonic gastric and intestinal conditions associated with neurasthenia. Three other writers of the same nationality have now confirmed these observations, and they conclude that though the action is transient, by giving small doses frequently, not only are gastric symptoms much relieved, but that the tone and activity of most of the tissues are likewise raised. The substance is called "paragangline" by its discoverer, but it has not yet found its way to the market in this country.

Influenzal Urethritis.

The medical practitioner from long experience looks with a suspicious eye on all cases of urethritis, for although there are circumstances under which the urethra becomes inflamed "idiopathically," they form an infinitesimal percentage of the whole. Gonococci or no gonococci, there are few urethral discharges that have not been acquired by venery, and the errant youth seldom finds a sympathetic listener when he pours his story of the proverbial "strain" into the doctor's ear. If, however, he reads the *Deutsche Medizinische Wochenschrift* for July 20th, he will be able in the future to find a fresh and less worn theory to account for his trouble. In that journal Cohn expresses the belief that many cases of urethritis may be due to the influenza bacillus, and he relates an instance from his own practice. The patient had a urethral discharge in which no gonococci were found, but on making cultures from the pus two organisms were obtained—a capsulated bacillus and Pfeiffer's influenzal organism. The disease proved refractory to treatment, and was followed by slight cystitis and epididymitis. In spite of the presence of the capsulative bacillus, Cohn thinks that the influenza bacillus was the etiological factor, both because it occurred in greater numbers, and because an epidemic of influenza broke out soon afterwards. As the patient admitted to coitus several days before the urethritis occurred, a simpler explanation will occur to most people, but Cohn has thought it worth while publishing the case. If his belief be a true one, influenza epidemics will have an added terror for the gilded youth.

Revision of the United States Pharmacopœia.

With the first of this month the eighth decennial revision of the United States Pharmacopœia became official, but the work is nearly five years overdue. The last decennial revision took place in 1890, so that the word "decennial" must be regarded as somewhat of an euphemism. A healthy sign lies in the actual diminution of the number of preparations admitted, the previous 994 being reduced to 958. In all 151 articles have dropped out, and 117 new ones taken their places. The principle adopted by the Convention for the revision seems to have been to place on the list not every drug of any value at all, but only those which are in demand, and though their selections will doubtless be criticised, most men might be able to manage their prescribing with the nine hundred and fifty-eight articles to choose from, without going to unofficial sources. Anti-diphtheritic serum finds a place for the first time, and the two animal products—adrenalin and thyroid extract—admitted, are the first of their kind. Although it was shown at the Brussels Conference in 1902 that it was hopeless at present to attempt an international pharmacopœia, the standards adopted by that Conference with regard to potent drugs have been accepted, the object being that all such preparations may be of uniform strength in civilised countries. The metric system has been adopted in indicating the average dose, followed by the approximate value in ordinary weights and measures in brackets. Even the tablespoon, dessertspoon, and teaspoon have not yet been ousted from their wonted position, but they have been ordered to contain definite quantities, namely, 16 cc. (or 4 fluid drachms), 8 cc. (or 2 fluid drachms), and 4 cc. (or 1 fluid drachm) respectively. It is noticeable, by the bye, that fluid extract is now spelt in one word.

A Famous Hospital Subject.

The death is reported from Vienna of Frau Magdalen Gelly, a well-known frequenter of the clinics as a "subject" for operative and other experiments. This remarkable woman was said to be gifted with a high degree of control over her respiratory apparatus whereby she was able to induce in herself a partial anæsthesia, retaining at the same time her consciousness. She was accustomed to allow the surgeons to perform various minor operations upon her body during which she would describe to them and to the assembled students the kind of sensations which she experienced. As she was in the habit of giving these *seances* twice a day for many years at a fee of three and sixpence, she is stated to have amassed quite a small fortune. Such a distinguished voluntary patient as this reminds one of the commoner type of medical examination "subject." Some of these individuals are old hands at the game and know instinctively whether the candidate is on the right track or not. When not absolutely on duty in this strange capacity they wax eloquent upon the nature of their tumour, the types of candidates who have examined them, and discourse in a learned fashion the pathology and prognosis of their affection. Others are just as reticent and afford the anxious candidate no clue whatever, having been fortified, in some instances, by a crown-piece to "let nothing out to the gentleman." A peculiarly morbid way of earning a livelihood, no doubt, but the hospital "subject" does not regard it in this light. Some people have a natural love of showing their physical abnormalities and imperfections to others, though it is rare to meet with individuals who willingly assist the surgeon in such a manner as Frau Gelly was able to do.

The Church and the Feminine Hat.

HISTORY has repeatedly shown that the religious world is apt to be torn asunder by factions founded on the slenderest issues. There is now some prospect of a war that will split up not only one but all the sects into two sharply divided camps, namely, those who favour and those who condemn the discarding of hats by women attending divine service. It has been suggested that the opposing parties be distinguished as the Hattites and Hussyites, but at this stage of the controversy the step seems somewhat unnecessary and flippant. The origin of the trouble lies in a nutshell. In the search for the simple life the gilded youth of both sexes have hit upon the plan of discarding head-gear indoors and outdoors. In pursuance of that principle a number of women have actually gone to church bare-headed. This act has been denounced by certain clergymen as ribald and blasphemous, and some have gone so far as to exclude hatless women from their churches. It is hard to comprehend on what grounds, religious or otherwise, the objection is based. If men can attend divine service without hats why not women? The Hebrew males keep on their hats in the synagogue as a point of ceremonial, but we know of no doctrine or revelation enjoining rules of any kind regarding hats upon Christian worshippers. From a medical point of view most forms of head-gear are open to serious objection, and wherever possible it would probably be best to do away with hats altogether. Now that the church has turned its attention to feminine millinery it is to be hoped that the matter will not stop at hats. That particular article of millinery is for the most part grotesque, extravagant, and absolutely unfitted for any rational defence against sun, wind, and weather. It is often loaded with the plumage of innocent birds, and, worse than all, has been provided at the cost of sweated workgirls and unpaid milliners. A thousand times better let a woman come hatless to church than worship in a fantastic hat obtained under such unmoral conditions. Let the clergy by all means extend their sumptuary restrictions to the gross extravagance of women's dress and ornaments, but it would be well to hesitate before checking the first voluntary attempt at simpler things. One thing is certain, that if going to church hatless becomes a fashion amongst women all the churches in Christendom will be unable to stop the way.

Overcrowding in Dublin.

THERE is no sanitary question at the present day more pressing than that of the healthy housing of the working classes and of the poor, and in no city of the Kingdom is the problem more important than in Dublin. As is well-known Dublin shows consistently not merely the highest death-rate in the United Kingdom, but one of the highest in Europe, and this death-rate is in the main due to a preponderance of diseases of the respiratory organs, phthisis being excessively common. The evil influences of overcrowding, however, are by no means limited to the spread of such infectious diseases as tubercle, but show themselves in the increased severity of every disease, and in a hundred and one social and moral results which tend to the degradation of the community. Dr. Antony Roche, in a valuable paper contributed to a recent number of the *New Ireland Review*, and reprinted (*a*), gives interesting figures comparing the condition as regards housing of the poor of Dublin with that of the poor of other cities. It appears that of the 59,263 families in Dublin, 21,747 or 36·7 per cent. live in tenements of one room each. This is the highest percentage in the Kingdom, Glasgow coming next with 26·11, and Belfast showing best among the large cities with only 1 per cent. Dr. Roche discusses at length the merits of the different methods of coping with the housing difficulty, and argues strongly in favour of the single-house plan as opposed to the artizan-block system. There is no doubt that a system of decentralisation such as the single-house plan involves presents many social and sanitary advantages, but the question is one that has to be decided in most cases by local considerations, such as distance and facility of transit. It is not to be forgotten, moreover, that difficult as is the question of housing the artizan, that of housing the very poor is infinitely more so.

Illegal Practice Abroad.

IT may be some consolation, however improper, to the members of our profession in these countries to reflect that they do not suffer alone in being subjected to the annoyance of the competition in practice of large numbers of unqualified persons. In other countries the evil is, if possible, even greater than here, and laws seem powerless to protect the public from the wiles of the mountebank America is, as is well known, the happy hunting-ground of the charlatan, and the lively imagination of the people of that continent seems to render them an easy prey to every kind of impudent imposture. In France, too, practice by unqualified persons has become so great an evil as to demand very sharp legal measures if the safety of the public is to be assured. In particular the number of so-called "masseurs" is in recent

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(*a*) "The Housing of the Working Classes." Dublin: Browne & Nolan. 1905.

years enormously increased, and many of these people hold themselves out to treat all diseases. It is true that unqualified practice is punishable by a fine in France, but the police are usually slow to move in such matters and only prosecute when they cannot avoid it. Even in cases of conviction, the fine imposed is only a matter of five or ten pounds, and this is barely a set-off against the advantages of the advertisement gained by the fact of prosecution. In a recent work on the subject Dr. Lèvre points out that the title "qualified masseur" (*masseur diplome*) is one which constantly deceives the public, who are unaware that the parchments conferring the title can be bought for so many francs from the enterprising dealer in diplomas, just as at one time a certain pseudo-prince did a large trade in bogus orders of honour.

Bacilluria in Typhoid Fever.

Since it was pointed out some years ago that the presence of typhoid bacilli in the urine of typhoid patients is a common occurrence, much attention has been paid to the necessity of taking steps to prevent infection by means of the urine. Formerly it was thought that if the fæces were properly sterilised or destroyed the risk of spreading the infection was minimised if not abolished, and no attention was paid to the urine as a separate factor. With the discovery, however, of the presence of bacilli in the urine, and more particularly with the recognition that bacilli may persist in the urine well on into convalescence, a wider view of the hygiene of typhoid fever is prevalent. It is now generally known by hospital physicians that a typhoid patient should not be discharged until repeated examinations have shown his urine to be sterile. In order to hasten this condition various plans have been devised, and various drugs employed. In cases where there is a distinct cystitis, irrigations of the bladder with mercuric chloride, with potassium permanganate, with boracic acid, with silver nitrate, and other antiseptics, have been made use of with varying success, while for internal use ureteropin has gained a high reputation. There seems little doubt that this drug, although it sometimes gives rise to untoward symptoms, usually has a marked influence in disinfecting the urinary passages. Dr. Easton, of Boston, U.S.A., in a recent paper (*a*) suggests an extension of its use. He thinks that it should be used not merely in cases where the urinary passages are already infected, but that if systematically employed in typhoid fever, it will have a beneficial effect in preventing the occurrence of bacilluria. Observations made in the Massachusetts General Hospital during last year have shown that with routine employment of the drug, the percentage of patients with typhoid bacilli in the urine was greatly diminished, so that it is probable the treatment will come into more general use.

(*a*) *Boston Med. and Surg. Journ*, August 17th, 1905.

PERSONAL.

Amongst the sufferers from the terrible railway accident last week at Witham we regret to note the name of Dr. Nicholls, of Glencoe, Cromer, who is reported as having sustained an "injury to the back."

The Francis Galton Scholar in National Eugenics, Mr. Edgar Schuster, will publish a report on his research into the inheritance of disease.

Surgeon Lieutenant-Colonel C. R. Kilkelly, C.M.G., M.B., B.Ch., D.P.H., late Grenadier Guards, has been appointed House Governor and Medical Superintendent of the Convalescent Home for Officers, Osborne, in room of Commander Powell, resigned.

Mr. Edgar Hoffmeister, M.B., M.R.C.S., has been appointed a member of the Consulting Staff of the Osborne Home for Officers.

Miss F. Sabin has been appointed Associate Professor of Anatomy in the Johns Hopkins University.

Mr. E. G. Bawden, of the Stock Exchange, London has given £100,000 to various medical charities and other works of benevolence. The division of this princely gift has been entrusted to Mr. Edgar Speyer. A list of the various charities benefited will be found in another column of the present issue;

The Right Hon. Lord Strathcona and Mount Royal, G.C.M.G., has been elected President of the Royal Institute of Public Health.

The Harben lectures at the Royal Institute commence on Oct. 10th. Professor Thomas Oliver, F.R.C.P., of Newcastle-on-Tyne, is this year's lecturer.

Special Correspondence.

[from our own correspondent.]

BELFAST.

Report on the Health of the City of Belfast for the Year 1904.—This report, just published, is, as in former years, chiefly remarkable for its brevity and incompleteness, and reflects anything but credit on the city and the Public Health Committee under whose auspices it is published. Belfast is a busy commercial city of about 360,000 inhabitants, with numerous different trades and occupations, yet the whole history of the public health department for a year is compressed into 45 pages, of which one is title, two are blank, and 16 or 18 are absolutely useless padding! The useful part of the report is comprised in 17 tables and some remarks on them. The first table shows the number of infectious cases reported during the years 1895 to 1904. They numbered last year 2,486, being less than any year since the Act came into regular working in the city. There were 1,018 cases of typhoid and simple continued fever, 635 of scarlet fever, 209 diphtheria, 135 small-pox, and 9 typhus. The second table shows the cases notified in the various dispensary districts, but as there is no map of the city, this is quite useless to the ordinary reader, who does not know exactly where the districts are situated. Table 3 shows the births and deaths for each quarter, and the chief causes of the latter. This shows that typhoid caused 111 deaths in the year—19, 20, 30, and 42 in successive quarters; while from diarrhœa the deaths were 251, of which no less than 158 were in the third quarter. The next table gives the numbers of deaths from different zymotic diseases in the past ten years. The most interesting point is that the typhoid deaths are less than any former year in the table.

Pages 9 to 15 of the report are padded with a geographical description of the various dispensary districts, apparently to assist the reader to mark them out on a map of his own, as no map is given, and no one can carry in his head the various boundaries. The next nine pages are filled with still more useless padding, a description of the weather month by month through the year 1904, and notes on the prevailing diseases. These pages appear every year in the report, and, indeed, constitute its main feature. It is full time they were dropped and some real information substituted for them.

Table 8 shows the annual birth and death-rate in the principal urban districts of Ireland in 1904. It appears that Belfast had a birth-rate of 31·6 per 1,000, only surpassed by Dublin with 32, the lowest being Drogheda with 23·1. The death-rate from zymotic disease was 2·7 in Dublin, 2·5 in Belfast, and only ·4 in Dundalk. The next table gives the rainfall month by month for 1903 and 1904 as recorded at the Antrim Road Water Works, but though interesting this is not entirely satisfactory, as this station is close to the hills and much wetter than the south and east sides of the city. The rainfall as recorded at Queen's College ought to have been given. The fall last year amounted to 37ins., and the year before to 44. Table 10 shows the average annual death-rate per 1,000 from phthisis and other chest affections in various Irish towns. The rates for phthisis vary from 1·3 in Newry to 4·6 in Cork, Belfast having 3·1, and Dublin 2·9, but these variations are small compared to those of the rate for other chest affections, which are indeed so great as to cause one to doubt their accuracy. The rate varies from ·7 in Drogheda and ·9 in Tralee, to 4·6 in Dublin, 4·9 in Belfast, and 7·4 in Galway. The rate from phthisis in Belfast shows a slow but steady improvement during the last ten years, and the four pages devoted to notes on this disease, and what is being done to combat it, are quite the best part of the report. The medical officers of the dispensary districts now notify phthisis voluntarily, and during the year 196 cases were notified by nine of the fourteen officers. All the houses where these cases occurred were visited by female sanitary inspectors, who gave instruction to the people on the advantages of fresh air, &c. Several pages are devoted to the study of the recent outbreak of small-pox, but this has already been fully discussed in your columns, so need not be criticized here. The only new feature in the report seems to be an addendum of two pages on the work of the inspector under the Factory and Workshop Act. He paid over 3,000 visits to factories, workshops, and bakehouses, and his visits resulted in the sanitary condition of many of these places being improved. Three charts showing the mortality week by week complete the report.

So much for the contents of the report. The omissions are much more remarkable. We are spending thousands on experiments at the sewage works, trying new schemes for the purification of the sewage and the improvement of the sanitary condition of Belfast Lough, but not a word of these matters is to be found. We have an expensive destructor for dealing with town rubbish, but no mention is made of it, and we are left to meditate on the popular report that it does not work, never has worked, and never will work. Of the ordinary routine work of the officials of the Public Health Department in inspecting drains, cleansing ashpits, &c., and inspecting meat and milk, we are left in blank ignorance. We would suggest that in his next report the Medical Officer of Health should inform us :—

1. In how many houses the drains have been inspected, and in how many found defective.
2. How many samples of food and drink have been analysed, and how many found adulterated.
3. How many carcases have been examined, and how many rejected as unfit for food.
4. What steps are being taken with regard to the flesh of tuberculous animals.
5. Whether any inspection of the great quantities of fruit now brought into the city from abroad takes place, and, if so, what the result has been.
6. How many days the destructor has worked, how many tons of rubbish it has destroyed, and what temperature is maintained in it.
7. What proportion of the sewage of the city is now dealt with by the bacteria beds, and what opinion he has formed as to their efficiency and economy.
8. Whether the united brains of his department would be equal to producing an index to his next report.

Obituary.

KEVIN IZOD O'DOHERTY, M.D.

The Australian mail brings news of the death at the age of 81, of Dr. Kevin Izod O'Doherty, the last of the Irish State prisoners who were transported to Tasmania for complicity in the insurrection of 1848. He was only a medical student in Dublin at the time, but with a brother-student, Richard Dalbie Williams, he started a revolutionary paper called *The Irish Tribune*, which was soon seized and suppressed by the Castle authorities. After a few years he was pardoned by Queen Victoria, and having taken his degrees in Dublin, he settled in Brisbane, the capital of Queensland. He sat in both Houses of the Queensland Parliament, and was also, on the invitation of Mr. Parnell, M.P. for Meath in the House of Commons for a brief period in the eighties.

DR. ERNST THEODOR SCHWEIGGER.

Dr. Ernst Theodor Schweigger, the eminent oculist, and Professor of Ophthalmic Diseases at the Berlin University, died last week after a long illness at Berlin.

CYRIL HENRY CAYLEY, M.A., M.B.Cantab. M.R.C.S., D.P.H.

We regret to announce the death of Dr. C. H. Cayley, Divisional Health Officer of the Bombay Municipality, which took place on July 31st, at Bombay. Dr. Cayley had one of his fingers injured some time ago, but it did not give much trouble until tetanus suddenly set in. He was removed to the hospital, where an operation was performed, but all the medical efforts to save his life proved futile. Dr. Cayley was born in September, 1865. His official record shows a brilliant University career and he held the Cambridge M.B., with the English M.R.C.S., and D.P.H. He went out to India about ten years ago on plague duty. He joined the Bombay Municipality as one of its Divisional Health Officers on January 27th, 1900, and held the appointment till the time of his death. Dr. Cayley leaves behind him a widow and small family, who only recently returned to England.

WILLIAM FULLER, M.B.T.C.D., L.R.C.S.I., J.P., OF OSWESTRY.

The death took place on the 29th ult. within a week of the completion of his ninetieth year, of Dr. William Fuller, a well-known practitioner of Oswestry. Dr. Fuller was a Bachelor of Medicine of Trinity College, Dublin, and began practice in Oswestry in 1842, the year in which he graduated. He enjoyed a large practice for forty years and retired in 1882. He was a Churchman and a consistent Liberal; but he took no part in public life. He was a justice of the peace for the borough, and sat regularly until his hearing began to fail.

FARQUHAR MATHESON, M.B., C.M. Aberdeen.

We regret to announce the death of Dr. Farquhar Matheson, of London, which occurred at his London residence on the morning of the 23rd ult. Dr. Farquhar Matheson was born of a Highland family in the parish of Kintail, on May 14th, 1840, so that he was in the sixty-sixth year of his age. After studying both at Glasgow and at Aberdeen, he graduated in medicine at the latter University in 1868, and then went to London, where he entered upon a successful professional career, and became recognised as a skilful specialist in diseases of the ear, nose, and throat. He was one of the surgeons of the Royal Ear and Throat Hospital, surgeon to the British and Foreign Musical Society, honorary aural surgeon to the Royal Caledonian Society, honorary surgeon to the Royal Scottish

Hospital, and a Fellow of several learned and scientific societies.

FREDERICK CHARLES MUDD, M.R.C.S., L.S.A., OF CHICHESTER.

WE regret to announce the death of Mr. Frederick Charles Mudd, M.R.C.S., L.S.A., who died at Chichester on the 24th ult. Born at Hadleigh, Suffolk, on January 22nd, 1840, he received his medical education at Guy's Hospital. He started his medical career at Uckfield, and afterwards joined his father, the late Dr. William Mudd, at West Pallant, Chichester, in which practice he continued till his death. For thirty years he held the honorary post of surgeon to St. Mary's Hospital, previously held by his father. He was also for some time assistant surgeon at the Chichester Infirmary, and in his earlier days he will be remembered as Secretary of the Sussex Branch of the British Medical Association. His death will be deeply regretted in the district. He took the M.R.C.S. of England in 1862 and the L.S.A. in 1866.

DR. THOS. HERBERT LITTLEJOHN.

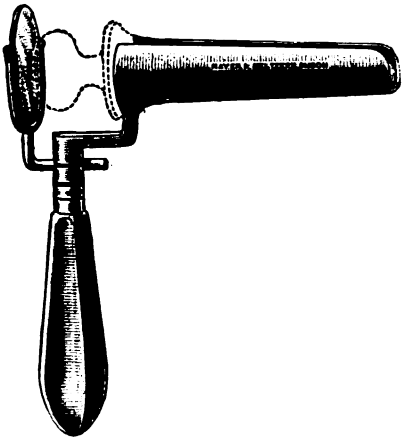
WE regret to announce the death of this gentleman, which occurred at his residence at Hampstead on Monday last after a brief illness of only three days. Deceased is the son of Sir Henry Littlejohn, M.D., of Edinburgh, for whom the deepest sympathy of the profession will be evoked. Dr. Herbert Littlejohn was appointed medical officer of health for the borough of Hampstead in 1901, and was only thirty-seven years of age. He was an ardent sanitarian, and much respected in the district.

New Instruments.

NEW IMPROVED RECTAL SPECULUM WITH MAGNIFYING LENS ATTACHED.

Suggested by Sir LAMBERT H. ORMSBY, M.D., F.R.C.S., ex-President of the Royal College of Surgeons in Ireland; Senior Surgeon of the Meath Hospital and Co. Dublin Infirmary.

All who have had much special practice in rectal surgery know how difficult it is in many cases to explore and ascertain accurately the appearances *in situ* of growths, ulceration, &c., and to observe as well the normal and abnormal mucous surface of the rectum some inches from the anal orifice. After careful exploration with the finger, one would always like to have an ocular inspection of the cause of pain, such as is produced by ulceration, abnormal growths, piles, or polypi in this region, and for such a purpose I have had an improved rectal speculum constructed which is easy of introduction with a split, or space, at the side, and open at each end, provided with a wooden plug to facilitate its painless introduction, and having at its lower end a convenient handle to hold it by. Attached to the outer opening of the speculum is a metallic half circular rim for the purpose of receiving a powerful magnifying glass lens which can be moved in any direction, but can at the same time if necessary be permanently fixed by screwing the handle up tight so as to grip the metallic bar which holds the lens.



This speculum and lens I have been using for the last few months, and it admirably carried out the object in view. It largely magnifies and thus enables the surgeon to see plainly the exact condition of the mucous surface of the lower rectum. I have to thank the eminent firm of instrument makers, Messrs. Mayer and Meltzer, 71, Great Portland Street, London, W., for the satisfactory manner in which they have carried out my idea in its construction.

The plate which illustrates this description accurately depicts the speculum in question. If it is desired to throw light into the speculum when introduced a small electric light can be used with great advantage.

Literature.

LAKE AND BARWELL ON LARYNGEAL PHTHISIS. (*a*)

MR. LAKE's concise and eminently practical monograph has ably met the want of the busy practitioner for a serviceable handbook on tuberculosis of the larynx. In the present edition Mr. Harold Barwell has exercised the function of editor with judgment and discretion and the book, although retaining its former appearance and justly valued useful characters has been revised, expanded, and thoroughly brought up-to-date. The author and editor wisely include references to cases dealt with in their practice at the Mount Vernon Hospital. The work admirably summarises the chief pathological and clinical features of laryngeal tuberculosis and offers a strong plea for early and active treatment. We regret that the old-fashioned and in many ways unsatisfactory title of the book should have been retained. We note also that "tubercular" is used throughout, whereas most modern writers now employ the more correct expression "tuberculous." Perhaps the most praiseworthy features of the volume, viewed at least from the standpoint of the general practitioner, are the excellent illustrations and the clear indications for treatment. The formulæ given in the appendix might with advantage be considerably extended. We commend this manual to the attention of all practitioners. It should do much to stimulate study of conditions at present sadly neglected.

MANUAL FOR CORONERS. (*b*)

THIS work is a guide to coroners' inquiries in South Australia, Australasia, and England. With index it numbers 153 pages, and is divided into eight parts, each of which is sub-divided into chapters.

Actual procedure—the same in the main in Australia as in England—is set forth step by step in a more practical and simple fashion than in any other work known to us. The first portion of each chapter in Parts I. to V. refers to coroners' law and procedure in South Australia (within the author's jurisdiction). The latter portion deals with the differences that exist in England and the various districts of Australasia, namely, in New South Wales, Queensland, Tasmania, Victoria, Western Australia, and New Zealand. Coroners, deputy coroners, and acting coroners are in Australasia, we are told (in Part I.), appointed and removable by the Governor-in-Council or by the Crown and are *ex officio* justices of peace. Any justice of the peace may—unlike English law—act as coroner with all the powers and authorities of such. He acts without fee, his expenses only being paid. Coroners in Australasia inquire into the cause and

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(*a*) "Laryngeal Phthisis or Tubercular Laryngitis." By Richar Lake, F.R.C.S. Second Edition, Enlarged and Re-written by Har Barwell, M.B.Lond., F.R.C.S.Eng., Laryngologist, Mount Vern Hospital. Pp. 120, with 45 illustrations, 20 of which are coloure London: Bailliere, Tindall and Cox. 1905. Price 6s. 6d.

(*b*) "A Manual for Coroners." By M. Ramsay Smith, M.B., B.S (Edin.), City Coroner for Adelaide. London: Hussey and Gillinghan 1904. 10s. 6d.

origin of fires—" whether a bush or other fire, whereby any building, ship, merchandise, or any stack of corn or hay, or any growing crop, pasture, or any other valuable effects shall be endangered, destroyed, or damaged." One of the most interesting sections is under Part V., on " Inquests in cases of Fire." In South Australia the coroner holds inquests in cases where there is evidence of arson or " of such carelessness as might give rise to suspicion against some one." In England, the author observes, the only one who has power to inquire into the cause and origin of fires is the City coroner within the City of London " acting for the Sheriff." The latter part of this statement is incorrect, the Sheriffs never having had any jurisdiction over fires. In Victoria a coroner cannot inquire into the cause of a fire until some person has paid five guineas to the Coroner with a request that he should hold an inquest.

In England if twelve of the jury do not agree as to their verdict the Coroner adjourns the inquest to the next criminal sessions. In Victoria if a majority of the jurors do not agree after two hours, the coroner may discharge them and hold a new inquest with an entirely new jury. The author very justly points out how illogical is the stereotyped verdict that deceased took his own life *in a fit of temporary insanity*, since the duration of the insanity is a subject on which the jury could not possibly have any real knowledge. The verdict in such cases should be merely whilst of unsound mind.

Literary Notes and Gossip.

The *Braille Weekly* forms one of the most remarkable of modern journalistic ventures. It is published in the well-known raised type for the use of the blind invented by Dr. Braille. A number of subjects are dealt with in its columns, or rather pages, including parliamentary and general news, special articles, chess problems and so on. We regret to note that the journal is not a financial success, and that appeals are being made for charitable support. It would be difficult to imagine any enterprise more worthy of support. Donations can be sent to the Editor, Braille Company, 24, St. Giles's Street, Edinburgh.

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The *Edinburgh Medical Journal* (New Series, Vol. XVII.) possesses a special interest in containing a series of portraits of some of those men who have helped to build up the fame of the Edinburgh School. These have been introduced as a fitting accompaniment to the centenary number of the journal, which forms the opening number of the present volume. In our review of the last volume we referred to the fact that just a century had passed since the first appearance of the journal in its embryo form, and this is now fittingly marked by a retrospect of the medical sciences extending over the lifetime of the publication. To all Edinburgh students this number must be welcome, showing as it does the part that their predecessors and contemporaries have played in establishing the fame of their school, and in adding to the fabric of medical knowledge. In the remainder of the volume one or two papers are of importance. That by Boyd and Beattie on " Decapsulation of the Kidneys," gives a good account of the changes found *post-mortem* in a kidney which had been decapsulated four months previously. As in other reports of similar cases, there was present marked adhesion between the kidney and surrounding structures; the capsule (apparently a new formation) was thick, stripped with difficulty, and in stripping caused considerable laceration. Within the capsule many large vessels were found, which, however, the writers think could hardly more than compensate for the normal communication between renal and peri-renal vessels necessarily destroyed by the operation. Another interesting paper is that on "Late Rickets," by W. Marsden, while that on " Poisoning in Scotland," by Francis Stewart, forms most entertaining reading.

"Anæsthetic Difficulties and How to Combat Them " is the title of a brochure by Mr. de Prenderville, anæsthetist to the Tottenham Hospital. It is a reprint of an article that appeared some little time ago in the Medical Press and Circular, and those of our readers who did not read it at the time will find it well worthy of their attention. It is brightly written, practical, and suggestive. Price 1s. nett.

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Messrs. Longmans, Green and Co. have issued in book-form the Report of the Committee of the Medico-Chirurgical Society which lately held an inquiry into the Phenomena attending Death by Drowning and the Means for Promoting Resuscitation in the Apparently Drowned.

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Mr. Theodore Dodd, a prominent character in the public life of Oxford, has written an open letter to the President of the Local Government Board, which deserves careful consideration not only by that Minister but by all who are concerned for the health of the nation. Mr. Dodd has secured a preface from the pen of Sir John Gorst, a circumstance which is in itself sufficient to command respect for its contents; for Sir John Gorst, however embarrassing he may be to his political friends, is recognised by the medical profession generally as a publicist of rare ability and disinterestedness. Mr. Dodd's object in his letter is a laudable one, namely, to show how much can be done for the physical infirmities of the nation by intelligent and sympathetic adminstration of the already-existing laws and governmental machinery.

£100,000 Gift to London.

Mr. E. G. Bawden, of the Stock Exchange and Clapton, has entrusted Mr. E. Speyer with a sum of cash and securities of about £100,000 to be applied to purposes of charity and benevolence and for the advancement of knowledge, especially in aid of human suffering. The gift to the Medical Charities is thus apportioned: *Hospitals*:—King Edward's Hospital Fund, £5,000; London Hospital, £5,000; City of London Hospital, Victoria-park, £3,000; Poplar Hospital, £3,000; National Hospital for the Paralysed, £3,000; Royal Waterloo Hospital, £2,500; Cancer Hospital, £2,500; German Hospital, £2,500; Queen Charlotte's Lying-in Hospital, £2,000; Clapham Maternity, £1,000; Royal Hospital for Incurables, £2,000. *Holiday Funds*:—Children's Holiday Fund, £10,000; Women's Holiday Fund, £2,000; Factory Girls' Holiday Fund, £2,000.

Convalescent and other Homes.—Metropolitan Convalescent Institution, £2,000; Mrs. Gladstone's Convalescent Home, £2,000; East Anglian Sanatorium, £1,000; Kelling Open-Air Sanitorium, £1,000; Mary Wardell's Scarlet Fever Home, £1,000; Homes for Aged Poor, Anerley, £1,000; St. Mary's Home, £2,000.

Institutions for Homeless and Crippled Children.—Dr. Barnardo's Homes, £2,000; National Refuges for Destitute Children, £2,500; Invalid Children's Association, £2,000; Haven for Homeless Little Ones, £2,000; Cripples Home for Girls, £1,000; National Home for Crippled Boys, £1,000.

Compulsory Notification of Measles.

The Plymouth Sanitary Committee last week resolved to recommend the extension for another twelve months of the compulsory notification of measles and whooping-cough, and the voluntary notification of pulmonary tuberculosis. In October the five years for which the Council experimentally adopted those measures will expire, and unless revoked before that time they will continue in operation. The Medical Officer of Health, Dr. Williams, has shown the startling fact that since notification has been in operation the death-rate from the two diseases named has been reduced from ·6 to ·3 per 1,000 per annum, a reduction of 50 per cent. This means that the adoption of notification has resulted in the saving of 110 lives which would have otherwise been sacrificed to measles or whooping-cough since 1900.

Notices to Correspondents, &c.

☛ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber, 'Old Subscriber," &c. Much confusion will be spared by attention to this rule.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

DENTAL (Isle of Man).—Dr. Miller of Berlin declares that antiseptics in dentifrices are wrong in principle as they are likely to destroy protective bacteria normally present in the month. The incidence of ordinary dental caries is not obviated altogether by vegetarianism, though there is some evidence to show that it may be thereby lessened.

M. O. H. (Doncaster).—There are only, as far as we can ascertain, about 80 authorised crêches in England. The question is under consideration by the L.C.C., for London at least.

DR. H. M.—The commonest accident among the Chinese miners in S. Africa is that of becoming "gassed" as, in spite of strict orders, they return before the effects of the blasting are quite over. The symptoms are sweating, drowsiness and severe headache which lasts for one or two days, and deaths are said to occur because they do not go into the hospital for treatment at once.

THE TREATMENT OF GONORRHŒA.

Referring to the paper by Mr. H. de Meric, which appeared in our issue for August 23rd, a Paris correspondent writes asking the dosage of argyrol. Having referred the question to the author of the paper, he replies that a 5 per cent. solution would be 5 grammes to 100 grammes of water or other vehicle.

DR. A. D.—The newspapers in the dead season, when there are no parliamentary proceedings and few law cases to report, are driven to appropriate other material to fill their columns. The cutting you enclose is an unfortunate example, but we have ascertained that the particulars were not supplied by the surgeon in charge of the case—with whom we commiserate—but by an official who should have been aware of the impropriety of such conduct.

A SIDE ISSUE OF THE DIMINISHING BIRTH-RATE QUESTION.

The question as to whether families with children should be accepted as tenants in flats is a pressing one, not in this country only, but in America. A recent issue of *Public Opinion* informs us that Cleveland has approached a step nearer the solution of the problem by forming a tenants' protective association. The citizens have grown weary of hearing the landlords dictate to them how and where they are to live, and how many if any children they are to be allowed, and have now come to the decision that any landlord refusing to accept as tenants a family which includes "children" shall be rigorously boycotted until he ceases to act the part of a tyrant, furthering the cause of race suicide.

HOSPITAL.—The Public Hospitals of New Zealand are State Institutions suported by compulsory rating, contributions and patients' fees. The medical men out there are agitating to be represented on the Board of Management.

DR. F. (Amersham).—Bromide of strontium is supposed to produce less acne, but seems to have no superiority over other drugs in arresting attacks of epilepsy. Hydrobromic acid cannot be given in sufficient quantity to be any service.

ERRATA.—In Dr. Wybrants Olphert's letter on "An Anti-vaccination Argument" which appeared in our last issue, the words "the Land of Services" should read "the Land of Jenner."

In our review of Dr. Gould's Dictionary of Medical Terms which appears in the same issue, the word "oonoiodiddibismuthmethylenedicresotinate," which our reviewer quoted from the work, should read "monoiodiddibismuthmethylenedicresotinate." A printer's error in such a case is however excusable.

DR. D. MACKAY.—Your paper on "The Functional Examination of the Ear by Means of the Voice" is marked for early insertion.

Vacancies.

Lister Institute of Preventive Medicine.—Assistant Bacteriologist. Salary £150 per annum. Applications to the Secretary, Lister Institute, Chelsea Gardens, London, S.W.

Hospital for Sick Children, Newcastle-on-Tyne.—Male Resident Medical Officer. Salary £100 per annum, with board, lodging and laundry. Applications to Alf. E. Birch, Secretary, Secretary's Office, Hospital for Sick Children, City Road, Newcastle-on-Tyne.

County Borough of Tynemouth.—Medical Officer of Health. Salary £300 per annum. Applications to E. B. Sharpley, Town Clerk, Town Hall, Tynemouth.

Metropolitan Water Board.—
A Senior Chemical Assistant. Salary £300 per annum.
A Senior Bacteriological Assistant. Salary £300 per annum.
A Junior Chemical Assistant. Salary £175 per annum.
A Junior Bacteriological Assistant. Salary £175 per annum.
Two Laboratory Assistants. Salary £75 each, per annum.
Applications to A. B. Pilling, Clerk of the Board, Savoy Court, Strand, W.C.

The University of Melbourne.—Professor of Anatomy. Salary £900 per annum. Applications to the Agent-General for Victoria, 142 Queen Victoria Street, London, E.C.

Medical Officer wanted for a Mining Co in Spain.—Salary £400 per annum, with house, attendance, fuel, lights, &c. Applications to Mr. Percival Turner, 4 Adam Street, Adelphi, London, W.C.

The Guest Hospital, Dudley.—Senior Resident Medical Officer. Salary £100 per annum, with board, residence, attendance, and washing. Applications to the Secretary.

Waterford County and City Infirmary.—Superintendent of Nurses. Salary £60 per annum, with board, &c. Applications to Secretary. (See Advt.)

Appointments.

ELLIS, F. H., B.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P., Assistant Resident Medical Officer at the London Open-air Sanatorium, Pinewood, Wokingham, Berks.

GLAISER, HOWARD, M.B., B.C.Lond., M.R.C.S.Eng., L.R.C.P.Lond., District Medical Officer, to the Mildenhall Union.

PANK, HAROLD W., M.R.C.S.Eng., L.R.C.P.Lond., District Medical Officer to the Caister Union.

ROUTLEY, EDWIN WALTER, M.D.Brux., M.R.C.S.Eng., L.R.C.P.Lond., Medical Officer of Health for Aldershot.

THOMPSON, ALEXANDER DEY, M.B., Ch.B.Glasg., Senior Assistant Medical Officer to the Monmouthshire Asylum, Abergavenny.

Births.

EVERY-CLAYTON.—On August 30th, at Rosslyn, Clevedon, Somerset, the wife of L. Ernest Every-Clayton, M.D., F.R.C.S., of a daughter.

TWEEDY.—On August 1st, at Abbey House, Kenilworth, the wife of Reginald Carlyon Tweedy, M.R.C.S., L.R.C.P., of a daughter.

Marriage.

HAY—GROVES.—On August 30th, at Holy Trinity Church, Weymouth, Archibald Gilchrist Hay, M.A., M.D., son of Alexander Hay, M.D., of Maryhill, Glasgow, to Mabel Constance, youngest daughter of Sir John Groves, of Rodwell, Weymouth.

Deaths.

LITTLEJOHN.—On September 4th, at 37 Buckland Crescent, Hampstead, after a short illness, Thomas Herbert Littlejohn, F.R.C.S. Ed., son of Sir Henry Littlejohn, Edinburgh.

McDONAGHY.—On September 3rd, at 5 Granville Place, Portman Square, London, Surgeon-General William McDonaghy, M.D., Indian Medical Service.

OPERATIONS—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopædic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Gt. Ormond Street, (9.30 a.m.), Gt. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynæcological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopædic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.) Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.35 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.) Samaritan (Gynæcological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopædic (2 p.m.), City Orthopædic (4 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.) Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, SEPTEMBER 13, 1905. No. 11.

EDUCATIONAL NUMBER, 1905—1906.

INTRODUCTORY REMARKS.

THE choice of a future calling is naturally one of the turning points in a man's life. Yet it is sometimes decided, as it were, by a mere straw of chance, and the young man drifts into a position that should be chosen only after a careful consideration of peculiar aptitudes and advantages of environment. Nowadays the medical profession has no welcome for the idle or the incompetent, who, indeed, have hardly the remotest chance of passing the test of qualifying examinations. Among learned professions, those of law and divinity can hardly be called progressive, whereas progress is inherent to engineering and certain other branches of intellectual activity; but of modern medicine it may be said that progress, unceasing, rapid and all-conquering, is above all things the great essential feature. Brilliancy of mind may still be essential to attainment of the front rank in the medical world, but none the less for the average practitioner sustained energy and devotion to his chosen life work will prove far more valuable ballast. Let parents, therefore, consider the solid and less showy virtues in determining the fitness or otherwise of a son, or of a daughter—for both sexes must now be included—for the practice of this most honourable but exacting profession.

As regards the material rewards of the profession, the aspirant should recognise from the outset that the labourers are many in proportion to the harvest. Any man who wishes to amass a fortune before middle age had better make up his mind to follow some business occupation. As a medical practitioner he will, as a rule, make enough to live upon within a short time of starting practice. Where there is much competition, however, he will find it hard to get beyond that amount, and as a rule his increased income is swallowed up by greater expenses. A large practice, whether general, special, or consultant, can be built up only by years of hard and conscientious work, at the end of which a moderate fortune will probably have been amassed. In all cases, the young medical man will find it desirable to be provided with a sufficient sum of money either to buy a practice or to furnish a house and tide over the first years of waiting. Should he wish to enter the Public Health Service he will have to devote several years to acquiring a special knowledge of the duties to be performed in the office of a medical officer of health. Or he may prefer to enter the Army, Navy, or Indian Medical Services, which carry pay from the time of appointment and confer a pension upon retirement; latterly something has been done to render these Services more popular, but much remains to be done in that direction. Then there are lunacy, Poor-law, and Local Government Board appointments, some of them well-paid and highly responsible posts. Lastly, the medical student may have made up his mind to tread the honourable but thorny paths of the consulting surgeon or physician, or of the specialist. In that case he must be provided with means to support him through ten years or more that will be required to enable him to earn a livelihood. Many men whose names have become household words have had to endure year after year of penury and self-denial. Indeed, no profession, not even excepting that of the barrister, could furnish more instances of hard living and high thinking than that met with in the ranks of consultant surgeons and physicians. On the other hand, the prizes to be gained in the higher branches of the profession are considerable, when tested by such acquisitions as social position, titles, honours, influence and substantial income. At the same time, it must be borne in mind that not a few men of unblemished reputation and of great intellectual and professional acquirements live and die without having gained the favours of fortune. To succeed in these directions requires the possession of moderate means, average intellectual endowments, good education, a hospital appointment, a good address, and an iron resolution. Success, moreover, requires a certain business-like attitude towards the affairs of life, the lack of which quality has blighted the career of many a good scientist and worthy citizen.

One of the fascinations of medicine is its variety, which in its endless wealth of detail compares with the "numberless laughter-dumplings" of the sea spoken of by the old Greek dramatist. To the larger mind which is capable of observing accurately and of generalising from ascertained facts, medicine is indeed a rich mine of Golconda. There is about it the fascination and joy of a daily encounter with a thousand difficulties and obscurities, any one of which may afford the clue to some discovery pregnant of relief to humanity for the rest of the ages. So far as evolution has advanced in medicine, it remains in many directions an inexact science. In other words, there still remains a wide margin of diseased conditions which the medical man is called upon to treat, but for which he can demonstrate no exact principles.

The individual judgment of the medical attendant is, therefore, still an all-powerful element in practice. Until medicine is reduced to an exact science such as mathematics this margin of inexactitude must persist, and give rise to the necessity of much rule-of-thumb practice. The more that is learnt, however, the less room is there for empirical procedure. The surgeon of to-day is fast reaching a stage of all-round exactitude, so far as it can ever be attained in dealing with so complex a thing as the human organism. It should be the aim of every medical student from the day he crosses the threshold of his profession always to seek for the principles that lie at the bottom of all that is practical in his profession. If he acquire this habit it will guide him through the thicket to many avenues of knowledge that would otherwise be impenetrable. For he must not forget that the greater part of his professional life will be passed away from teachers and hospitals in places where he will have to observe and act for himself. Some epoch-marking discoveries have come from the ranks of the general practitioner, and assuredly it is never the material that is wanting.

THE CHOICE OF A SCHOOL.

The choice of a medical school often hinges upon the accidents of time, place, or tradition. Many students nowadays go to one of the excellent provincial schools in their neighbourhood. Many others, again, are attracted to the Universities, North or South of the Tweed, or across the Irish Channel, which grant the degree of M.D. without exacting an abnormally high standard of examination. Men who are receiving their general education at one of the Universities will naturally enter the medical school attached to their Alma Mater, at any rate for a portion of the five years' medical curriculum. In some few instances the possession of a University qualification is made a *sine quâ non* in the holding of some coveted hospital or other professional appointment. There may be some sort of excuse for this species of organised " protection," which the labouring classes would call " trades-unionism," in the case of the professorships and examinerships in some of the ancient Universities. When a similar exclusion, however, is applied by medical charities the situation becomes intolerable. The fact remains, however, that in the majority of English hospitals and infirmaries none but London graduates and diplomates need apply. A newly formed association of Scotch Diplomates—many of whom are Englishmen and Irishmen—are calling attention to the unfairness of the conditions that exclude them from holding honorary appointments on the medical staffs of many English charities. These facts may possibly furnish useful hints to the intending student, who has to make the best of present conditions.

THE CHOICE OF QUALIFICATIONS.

The student is early called upon to define his aims ; in other words he has to decide through what portal he will enter the profession. The point is one of unquestionable importance, because there is no going back on the choice later in the student-career. The reorganisation of the University of London has rendered it possible for the average student to obtain a degree in medicine on terms less prohibitive than was formerly the case, but the fact remains that although the purely medical standard is attainable by any fairly diligent student, the matriculation examination and that in science nevertheless constitute serious stumbling blocks. The average student will probably find it more convenient to take the diplomas of the English Conjoint Board, and, should he deem a degree worth the extra trouble, he can put in attendance at one or other of the provincial Universities with the view of subsequently passing the examinations for the doctorate. Or he may choose to take a qualification or degree in the Scotch or the Irish schools, where education is sound, practical, and well-equipped, and the traditions of the teachers are unrivalled.

THE COURSE OF STUDY.

It is unnecessary to discuss the details of the medical curriculum. We would, however, impress upon the student the importance of entering upon his work earnestly, with firm determination to familiarise himself with the subjects—anatomy, physiology, and materia medica—which constitute the threefold basis of practical medicine. With regard to anatomy, the only valuable knowledge is that gained by actual dissection of the dead body. Verbal descriptions and plates are only aids to knowledge, not knowledge itself. Dissection gives information at first hand—actual knowledge, not mere statements—and the practice of dissection is, in fact, a first course in surgery. We would warn the student against that form of intellectual laziness which consists in abandoning the dissecting room in favour of the library. At the same time, an exception must be made so far as an excellent stereoscopic atlas of anatomy is concerned ; it affords a capital means of refreshing the memory of details of past work done in the dissecting room. The midnight oil may enable the student to pass examinations, but it will never confer that intimate familiarity with the things themselves, which is indispensable to success in practice. Nor should he despise that somewhat arid subject, materia medica. A knowledge of the physical properties of drugs and of their physiological action is all-important to the hospital physician as to the general practitioner. Treatment is the ultimate object of all medicine, and the medicinal treatment of disease is still an integral part of the practice of medicine.

THE CLINICAL WORK.

It is in the wards and in the out-patient department, after all, that the student acquires most of his information concerning the course and treatment of disease. There he watches the daily progress of morbid processes, and learns the means employed to afford relief or to bring about recovery. It will be his privilege to unravel the tangled threads of each patient's life-history, and by the careful examination of data to arrive at a reasoned conclusion known as the diagnosis. In this way he will gradually learn to recognise the main principles which underlie the practice of medicine. Each patient who comes under his observation will, if properly studied, yield his quota of practical knowledge, and the value of the opportunity depends upon the ability and willingness of the student to avail himself thereof. The object and aim of clinical training is to cultivate the student's powers of direct observation and to train him to make correct deductions, and the habit of careful observation is one which should become second nature. The instruction received in the wards is incomplete unless supplemented by the lessons to be learned in the post-mortem room. There the student can follow the morbid process to its conclusion. The post-mortem room is the natural complement of the ward, and it is often only in this room that the clinical problem is unravelled, and the student enabled to observe the organic lesions which determined the symptoms he has been studying. Incidentally the student should learn as much as he can of the method of carrying out these examinations, for it falls to the lot of most practitioners to have to make such examinations, and errors of observation or appreciation may be fraught with the gravest consequences to possibly innocent persons.

The Higher Qualifications.

There remains the question of the higher qualifications, *e.g.*, the Fellowships of the Royal Colleges, which are indispensable to those who contemplate a hospital career, either as physician or surgeon. The Fellowship of the London Royal College of Physicians is not obtained by examination, but by selection from among the members, but it is nevertheless demanded as a necessary qualification in the holding of many hospital appointments. Candidates for the membership are required to pass a searching examination and to satisfy certain other requirements before they can be admitted thereto, and subsequent elevation to the Fellowship is largely a matter of personal influence, though merit *per se* is not a bar to selection. The Fellowship of the Royal College of Surgeons, on the other hand, is a purely professional distinction, and is open to anyone who can pass the examinations. It is advisable to pass the first examination for the Fellowship as soon as possible after passing the first membership, in order not to have to go over the ground later a second time. The Fellowships of the Scotch and Irish Colleges of Surgeons are conferred after examination, but are not recognised as qualifying for staff appointments by the majority of large English medical charities.

Choice of a Career.

When the student has entered the portals of the profession he is confronted with the question of deciding in what particular path he shall direct his energies. Many neo-practitioners, not unwisely, spend a year or two in resident appointments at their own hospitals or at some provincial hospital or infirmary. Others, again, either join their parents in practice or purchase partnerships. Then, too, there are the Services—Indian, Army, Navy, and Colonial—to choose from. The Poor-law Infirmaries provide each year a certain number of appointments, and these are the first rungs of the ladder which leads to the superintendency of these institutions. These posts are fairly remunerated, and afford reasonable security of tenure, but they entail much hard work, together with heavy responsibilities.

Public Health Service.

Every student who can afford the time is strongly advised to qualify in State Medicine, since this diploma renders its holder eligible for appointment as medical officer of health, and, moreover, the knowledge thus gained is valuable in every department of practice. A diploma in State medicine entails a special course of preparation and training subsequent to qualification, the conditions of which will be found under the appropriate heading. Although the tenure of office is not as yet on a satisfactory basis, there are many appointments of the kind which afford a free field for intelligent activity.

Post-Graduate Instruction.

Medicine has of late years become a field of vastly wider extent and when he enters upon his professional work the conscientious practitioner is apt to experience a painful sense of his shortcomings in many branches of medical practice. The knowledge which has been rendered available of recent years has obviously placed a peculiar responsibility upon the physician fresh from his studies. The desire so generally felt by men in practice to extend and complete their knowledge of special subjects has led to the organisation of post-graduate institutions on a large scale, of which advantage is freely taken by those who are fortunate enough to reside within accessible distance thereof. We would strongly urge senior students and young practitioners to avail themselves of every opportunity to acquire a working knowledge of the various special branches—eye, ear, throat, gynæcology, and so on. This leads us to the question of

Specialism in Medicine.

Hitherto the student has been taught that "the greatest mistake of all is to start in a specialty without being thoroughly grounded in general practice." The statement is undoubtedly true to the extent that it behoves everyone, no matter what particular department of practice he may decide to adopt, to acquire a thorough grounding in the general principles and practice of medicine. On the other hand, there is much to be said in favour of the view that it is best for the young practitioner to make his choice at the earliest possible moment of the line of work which he designs to follow. As soon as he has qualified, therefore, or as soon after as may be, the intending specialist should endeavour to obtain a junior post in one or other of the special hospitals, where he can gradually work his way up.

Medical Practice in Foreign Countries.

Practitioners qualified in Great Britain who desire to practise their profession abroad are still confronted with many difficulties. True, a step in the direction of reciprocity has been taken in the case of Italy, but elsewhere in Europe considerable difficulty will be experienced in obtaining permission to practise; indeed, it is usually necessary to go through the whole curriculum and pass the examinations in their entirety.

THE ENGLISH UNIVERSITIES.

The English Universities are eight in number, viz., Oxford, Cambridge, London, the Victoria, Durham, Liverpool, Leeds, and Birmingham. The choice of a University is usually determined by social, geographical, and financial considerations. Evidently students whose parents are able and willing to incur the necessary expense would do well to select one or other of the ancient Universities, since their degrees confer upon their holders a status not accorded by the public to the degrees of more modern educational institutions. To those less favoured by fortune, but blessed with energy and a fair share of intelligence, the London University offers ample scope, and its degrees are recognised as the outward and visible sign of high professional attainments. A capable and industrious student, however, may equally well lay the foundations of success in one of the newer provincial universities.

OXFORD.

There are two degrees in medicine, B.M. and D.M., and two degrees in surgery, B.Ch. and M.Ch. The B.M. and B.Ch. degrees are granted to those members of the University who have passed the second (B.M.) examination. Graduates in Arts, B.A., are alone eligible for these degrees. In order to obtain the degrees of B.M. and B.Ch., the following examinations must be passed :—1. Preliminary : Subjects :—Physics, chemistry, zoology, and botany. 2. Professional (*a*) First examination (held twice a year) : Subjects :—Organic chemistry, unless the candidate has obtained a first or second class in chemistry in the Natural Science School ; Human physiology, unless he has obtained a first or second class in animal physiology in the Natural Science School; Human anatomy; Materia medica with pharmacy. (*b*) Second examination: Subjects:—Medicine, surgery, midwifery, pathology, forensic medicine with hygiene. The approximate dates of the examinations are as follows:—Preliminaries:—Physics, and chemistry, December and June; Zoology and botany, December and March; Professional (First and Second B.M.), June and December.

The degree of D.M. is granted to Bachelors of Medicine of the University who have entered on their thirty-ninth term on their presenting a dissertation approved of by the appointed professors and examiners.

The degree of M.Ch. is granted to Bachelors of Surgery of the University who have entered their twenty-seventh term, who are members of the surgical staff of a recognised hospital, or have acted as dresser or house surgeon in such a hospital for six months, and who have passed an examination in surgery, surgical anatomy, and surgical operations. This examination is held annually, in June.

The First examination for the degrees of B.M. and B.Ch. may be passed as soon as the Preliminary Scientific examinations have been completed. The subjects of this examination may be presented separately or in any combination or in any order, provided anatomy and physiology be offered and passed together.

In the Second Examination candidates are allowed to present themselves in Pathology, and also in Forensic Medicine at separate Examinations at any time after the First Examination has been passed; but no candidate is permitted to enter for the Examinations in medicine, surgery, and midwifery until he has attained the twenty-fourth term from his matriculation—*i.e.*, six years.

Diploma in Public Health.—An examination is held yearly in Michaelmas Term. The first part comprises the application of chemistry and physics to general hygiene. The second part comprises the following subjects:—General pathology, with special relation to infectious diseases; the laws relating to public health; sanitary engineering; vital statistics. Both parts may be taken together at the same Examination, or they may be taken at separate Examinations; but no one is deemed to have satisfied the Examiners in Part II. unless he has satisfied the Examiners in the subjects of Part I. A diploma is issued to every candidate who has passed in both parts of the Examination, but no Diploma or Certificate is given under any other circumstances. Candidates must have their names on the "Medical Register" and must have satisfied all the Rules of the General Medical Council of the United Kingdom relating to the admission of Candidates for Diplomas in Public Health which are in force at the time.

More detailed information may be obtained from the "Examination Statutes" with the "Regulations" for the current year, published annually in June at the Clarendon Press Depot, price 1s.

CAMBRIDGE.

At the University of Cambridge five years of medical study are required for the M.B. and B.C. degrees. The candidate must have resided nine terms (three years) in the University, and have passed the "previous" examination in classics and mathematics. There are three examinations: The first in (1) chemistry and physics, and (2) biology; the second in human anatomy and physiology; and the third in (1) pharmacology and general pathology, (2) in surgery, midwifery, and medicine. The first and the third examinations are divided into two parts, which can be taken separately. Subsequently to the third examination an Act has to be kept which consists in reading an original thesis, followed by an oral examination on the subject of the thesis. As the subjects for the examination for the degree in surgery are included in the third examination for the M.B. degree, candidates are admitted to the degree of Bachelor of Surgery on passing the third examination for Bachelor of Medicine.

The M.D. degree may be taken three years after the M.B. An Act has to be kept, including the presentation of an original thesis, with oral examinations and an essay to be written extempore. There is also the degree of Master of Surgery, for which the candidate, having already passed for B.C., or being M.A., has otherwise qualified in surgery, has to pursue extra study in surgery, and has a special examination or submits original contributions of merit to the science or art of surgery. The yearly expenditure of a student who keeps his term by a residence in a college is from £150 to £200 a year. This, however, may include all payments to the University and the College—all fees as well as clothes, pocket money, travelling expenses, &c. Non-collegiate students have only to pay the University fees, which are not large. They lodge and board as they like; their expenses, therefore, are entirely in their own hands.

The University grants a diploma in public health without the necessity of residence, the examination being in so much of State Medicine as is comprised in the functions of officers of health, and subject to the latest requirements of the General Medical Council. These examinations are held in Cambridge the first week in April and October. Candidates, whose names must be on the "Medical Register" of the United Kingdom, and need not be members of the University, should send in their applications to the Secretary of the State Medicine Syndicate a fortnight in advance. Every candidate who has passed both parts of the examination to the satisfaction of the examiners will receive a testimonial testifying to his competent knowledge of the subjects comprised in the duties of a medical officer of health.

There is also a special examination in Tropical Medicine and Hygiene, held annually in August. It is open to qualified practitioners under certain conditions as to previous study and experience. Successful candidates receive a University Diploma.

An abstract of all Regulations may be obtained upon sending a stamped directed envelope to the Assistant Registrar, Cambridge. Full information is contained in the University Calendar.

UNIVERSITY OF LONDON.

The Medical Faculty grants the degrees of Bachelor of Medicine and Surgery, Doctor of Medicine and Master in Surgery. Under the new regulations the students are divided into "Internal" and "External." An internal student is one who has matriculated at the University and is studying in a school approved by that body, or under the teachers of the University. An external student is one who has adopted an alternative course of study. The regulations differ somewhat in their application to the two groups of students. We only propose to deal with them as they affect *internal* students, since the special information required by the others had best be obtained direct from the Registrar. Under no circumstances will a student be admitted to the final examination for a degree until at least three years have elapsed since matriculation or other examination entitling to registration as a medical student.[*]

The Matriculation Examination takes place thrice yearly—in January, June (or July), and September. Application for admission to it must be made on a special form about six weeks beforehand, and the candidate must have completed his 16th year at the date of the examination. Candidates must show a competent knowledge of five subjects, among which

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[*] May obtain registration as Internal or External students on presentation of documentary evidence as to their condition and a payment of £2: Graduates of such British, Colonial, and foreign Universities as are approved by the Senate for that purpose, and those who have passed all the examinations required for a degree in those Universities. also women who have obtained Tripos certificates granted by the University of Cambridge, and women who have obtained certificates showing that, under the conditions prescribed by the Delegacy for Local Examinations at Oxford, they have passed the Second Public Examination of that University or have obtained honours in the Oxford University Examination for Women in Modern Languages, and students who hold the Scotch School Leaving Certificate, having passed on one and the same occasion, in the Higher or Honours Grade in all the subjects required by the regulations for the Matriculation Examination.

must be English and elementary mathematics. The other three (one of them a language) may be selected from the following:—Latin, Greek, French, German, Arabic,* Sanscrit,* Spanish,* Portuguese,* Italian,* Hebrew,* Ancient History, Modern History, Logic, Physical and General Geography, Geometrical and Mechanical Drawing, Mathematics (more advanced than in the compulsory examination), Elementary Mechanics, Elementary Chemistry, Elementary Biology (Botany), Elementary Biology (Zoology),* Elementary Physics, Heat, Light, and Sound, Electricity, and Magnetism. Candidates who desire to be examined in the subjects against which an asterisk is affixed must give at least two months' notice.

The Preliminary Scientific Examination will take place twice in each year, in January and July. It will consist of papers in chemistry, biology, and physics, and there will be a practical examination in each subject. Examiners will also be at liberty to test candidates *viva voce*. A student may present himself for examination in each of the three subjects, separately or in all at the same time. Part I. of this examination includes papers in inorganic chemistry, physics, and biology, with practical examinations; Part II. is an examination in organic chemistry.

The Intermediate Examination in Medicine will take place twice a year, January and July. Candidates must have passed the Preliminary Scientific Examination at least two years previously. The subjects of examination are Anatomy, Physiology and Histology, and Pharmacology, including Materia Medica. Candidates who have failed in one subject only at this examination may offer themselves for re-examination in that subject, if permitted to do so by the examiners. Three scholarships, one of the value of £40 in Anatomy, another of the same amount in Physiology, and one of £30 in Pharmacology may be awarded by the examiners to any candidate who has passed the whole of the examination at one time.

Provincial Examinations for Matriculation.—These examinations are appointed by the Senate from time to time upon the application of any city, institution, or college desiring to be named as a local centre for one or more examinations in London under the supervision of sub-examiners also appointed by the Senate. Candidates wishing to be examined at any centre must give notice upon their forms of entry to the Principal of the University. Besides the University fee a fee usually varying from £1 to £3 is charged by the local authorities and must be paid *at the local centre* before the commencement of the examination.

The Final M.B., B.S., Examination will take place twice a year, in October and May. No candidate will be admitted to this examination unless he has completed the course of study prescribed in the schedule or in less than two academic years from the date of passing the Intermediate Examination in anatomy and physiology.

The subjects of the examination are Medicine (including Therapeutics and Mental Diseases), Pathology, Forensic Medicine and Hygiene, Surgery, and Midwifery and Diseases of Women. The subjects may be divided into two groups, one of which shall comprise Medicine, Pathology, Forensic Medicine and Hygiene; and the other Surgery, Midwifery and Diseases of Women. Either group may be taken first at the option of the candidate, or the groups may be taken together.

Only candidates who show a competent knowledge of all the subjects comprising a group will be passed. The examiners will be empowered to recommend the award of a University Medal to the candidate who has most distinguished himself in the whole examination.

Doctor of Medicine.—The examination for the degree of Doctor of Medicine will be held twice in each year, in December and July. Every candidate must have passed the examination for the M.B., B.S., of this University. Candidates may present themselves for examination in one of the following branches: (1) Medicine, (2) Pathology, (3) Mental Diseases, (4) Midwifery and Diseases of Women, (5) State Medicine; and if they wish, may pass also in another branch at a subsequent examination. Candidates for Branches 1 to 4 who have taken honours at the M.B., B.S., examination in the subject in which they present themselves for the M.D. degree, or who, subsequently to taking the M.B., B.S., have conducted a piece of original work approved for the purpose by the University, or have had special experience approved by the University, may present themselves for the M.D. examination one year after taking their Bachelor's degree. Other candidates must show that they have taken the degree of M.B., B.S., not less than two years previously; and as regards candidates in Branches 1 to 4, that subsequently to taking that degree they have held for at least six months a resident or non-resident medical hospital appointment, or that they have been in qualified practice for not less than five years, while candidates in Branches 2 and 3 must show that they have held in the one case a pathological and in the other an asylum appointment. In each branch there will be (1) two papers on the special subject of the branch; (2) a clinical examination; (3) an essay to be written on one of two given subjects connected with the branch. In Branch 1 there will also be a paper on pathology, and in Branches 2, 3, and 4 a paper in medicine, while in Branch 2 a laboratory examination will be substituted for the Clinical Examination held in the other branches.

Candidates in Branch 5 (State Medicine) must show that they have taken the degrees M.B., B.S. not less than two years previously, and that subsequently to taking those degrees they have had (1) six months' practical instruction in an approved laboratory; (2) six months' practical instruction from a medical officer of health, of which three must not coincide with the laboratory work, and three months' practice at a hospital for infectious diseases. The interval between passing the M.B., B.S. and proceeding to the M.D. State Medicine may be reduced to one year, subject to conditions corresponding to those affecting Branches 1, 2, 3, and 4.

Master of Surgery.—The examination for the degree of Master in Surgery will take place twice in each year, commencing on the same dates as the foregoing, and the general regulations already quoted with regard to the M.D. will practically apply to it, surgery being substituted for medicine. The examination will consist of (1) two papers on surgery (one of which may be a case for commentary); (2) an essay to be written on one of two subjects which may be selected from any branch of surgery; (3) two papers on surgical pathology and surgical anatomy; (4) a clinical examination; (5) operations on the dead body; (6) a *viva voce* at the discretion of the examiners. Competent knowledge in every subject of the examination must be shown in order to pass.

For the M.S. degree and all branches of the M.D. a candidate is at liberty to forward a thesis or copies of published works embodying the result of independent research in the subject in which he presents himself for a degree and also any printed contributions to the advancement of professional knowledge published either separately or conjointly. If the examiners consider such thesis or works of sufficient merit they are empowered to exempt a candidate partly or entirely from examination in the subject to which such work refers. They also have power to award a University Medal to the candidate who at the examination in any branch passes with most distinction.

Fees.—This University has established centres for preliminary and intermediate studies at University and King's Colleges. The fees for the courses at these colleges are arranged in two scales:—(*a*) For courses required by the University of London. 1. Preliminary scientific (Part I.) course, fee £26 5s. Repetition (practical and lectures), fee £4 4s. per subject (physics, chemistry, botany, and zoology); attendance for one year. 2. Preliminary scientific (Part II.) course and Intermediate course, fee £57 15s. in one sum, or £63 in two instalments; attendance, anatomy, and physiology (with one in each course of practical physiology) during three years, and one in organic chemistry (Preliminary Scientific, Part II.), pharmacology, and materia medica. Repetition: Fees £3 3s. for physiology and anatomy and £4 4s. for other subjects; attendance for three months. (*b*) For courses for examinations by the Conjoint Board. 1. First examination (Parts I., II., and III.,) course, fee £21. Repetition (chemistry, physics, and biology), fee £3 3s. 2. First examination (Part IV.) course and second examination course, fees £57 15s. in one sum, or £63 in two instalments; attendance for three years, with one at practical physiology courses. Repetition (practical physiology), fee £3 3s. Anatomy and physiology, fee £3 3s. for each subject; attendance for every three months' work beyond the three years. Students may enter these courses either through the medical schools at present connected with these centres or through St. George's Hospital Medical School or Westminster Hospital Medical School; they may also enter these centres directly and choose their medical school subsequently. Information on these points may be had of the Academic Registrar, University of London, South Kensington.

UNIVERSITY OF DURHAM.

One diploma and six degrees in Medicine and Hygiene are conferred, *viz.*, the degrees of Bachelor in Medicine, Bachelor in Surgery, Master in Surgery, Doctor in Medicine, Bachelor in Hygiene, and Doctor in Hygiene, and Diploma in Public Health. These degrees are open to both men and women.

For the degree of Bachelor in Medicine (M.B.) there are four professional examinations. The subjects for the first are: Elementary anatomy and elementary biology, chemistry, and physics. For the second: Anatomy, physiology, materia medica, therapeutics, and pharmacology. For the third: Pathology, medical jurisprudence, public health, and elementary bacteriology; and for the fourth: Medicine, clinical medicine and psychological medicine, surgery and clinical surgery, midwifery, and diseases of women and children.

It is required that one of the five years of professional education shall be spent in attendance at the University College of Medicine and the Royal Infirmary, Newcastle-upon-Tyne. First and second year students (dating from registration) are not required to comply with the regulation regarding attendance on hospital practice. Candidates who have passed the First and Second Examinations of the University will be exempt from the First and Second Examinations of the Conjoint Board.

For the degree of Bachelor in Surgery (B.S.) every candidate must have passed the examination for the degree of Bachelor of Medicine of the University of Durham, and must have attended one course of lectures on operative surgery, and one course on regional anatomy. Candidates will be required to perform operations on the dead body, and to give proof of practical knowledge of the use of surgical instruments and appliances.

For the degree of Master in Surgery (M.S.) candidates must not be less than twenty-four years of age, and must satisfy the University as to their knowledge of Greek or German. In case they shall not have passed in either of these subjects at the Preliminary Examinations in Arts for the M.B. degree, they must present themselves at Durham for examination in it at one of the ordinary examinations held for this purpose before they can proceed to the higher degree of M.S. They must also have obtained the degree of Bachelor in Surgery of the University of Durham, and must have been engaged for at least two years subsequently to the date of acquirement of the degree of Bachelor in Surgery in attendance on the practice of a recognised hospital, or in the naval or military service, or in medical or surgical practice.

For the degree of Doctor in Medicine (M.D.) candidates must be of not less than twenty-four years of age, and must satisfy the University as to their knowledge of Greek or German. In case they shall not have passed in either of these subjects at the Preliminary Examinations in Arts for the M.B. degree, they must present themselves at Durham for examination in it at one of the ordinary examinations held for this purpose before they proceed to the higher degree of M.D. They must also have obtained the degree of Bachelor of Medicine of the University of Durham, and must have been engaged for at least two years, subsequently to the date of acquirement of the degree of Bachelor of Medicine, in attendance on the practice of a recognised hospital or in the naval or military services, or in medical or surgical practice.

Each candidate must present an essay which has been prepared entirely by himself, and which must be typewritten, based on original research or observation, on some medical subject selected by himself, and approved by the Professor of Medicine, and must pass an examination thereon, and must be prepared to answer questions on the other subjects of his curriculum, so far as they are related to the subjects of the essay.

For regulations for degrees in Hygiene and for the diploma in Public Health see Calendar 1905-6.

Candidates for any of the above degrees must give at least twenty-eight days' notice to the Secretary of the College of Medicine, Newcastle-on-Tyne. In the case of the M.D. (Essay) Examination, candidates must send in their essays six weeks before the date of the examination.

Attached to this University for the acquirement of medical study and hospital practice, is the Royal Infirmary, a very commodious and ornate building, with 280 beds. A new wing is in course of erection, which will accommodate the departments of physiology and bacteriology, and contain a students' gymnasium and a set of students' union rooms, and will be completed by the summer of 1906. Pathological demonstrations are given as opportunity offers. The New Royal Victoria Infirmary, containing 450 beds, is approaching completion, and will be opened in the course of next summer. In the new infirmary adequate accommodation will be provided for the study of the various special subjects, in addition to the ordinary clinical work. Practical midwifery can be studied at the Newcastle Lying-in Hospital. Opportunities for practical study are also afforded by the Dispensary City Infectious Diseases Hospital, Eye Infirmary, and at the Northumberland County Lunatic Asylum.

There are various appointments open to the students, some carrying with them an honorarium, whilst the scholarships available are numerous and of considerable value.

Fees.—(*a*) A composition ticket for lectures at the college may be obtained—1. By payment of 72 guineas on entrance. 2. By payment of 46 guineas at the commencement of the first sessional year and 36 guineas at the commencement of the second sessional year. 3. By three annual instalments of 36, 31, and 20 guineas, respectively, at the commencement of the sessional year. (*b*) Fees for attendance on hospital practice: For three months' medical and hospital practice, five guineas; for six months, eight guineas; one year, twelve guineas composition fee in one payment, twenty-five guineas; or by three instalments at the commencement of the sessional year, *viz.*, first year, 12 guineas second year, ten guineas; third year, six guineas; or by two instalments, *viz.*, first year, fourteen guineas, second year, twelve guineas. In addition, two guineas yearly up to three years must be paid to the Committee of the Royal Infirmary.

Residence can be had in a separate hostel for female students at moderate inclusive fees for board, &c., particulars of which and any other college information will be given on application to Prof. Howden, Secretary, University of Durham College of Medicine, Newcastle-on-Tyne.

MANCHESTER UNIVERSITY.

Candidates for degrees in medicine and surgery must attend classes in the University during at least two years.

The degrees in the Faculty of Medicine are Bachelor of Medicine (M.B.), Bachelor of Surgery (Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). All candidates for degrees in medicine and surgery are required to pass the Matriculation Examination, or to have passed such other examination as may from time to time be recognised for this purpose by the University.

The subjects of the Matriculation Examination are—1, Latin; 2, mathematics; 3, mechanics; 4, English and history; 5, one of the following:—(*a*) French; (*b*) German; (*c*) Greek; (*d*) Italian; (*e*) Spanish; (*f*) any other modern language, permission to present which has been obtained from the Joint Matriculation Board. Notice of intention to present either Italian or Spanish must be given to the Secretary, Joint Matriculation Board, Manchester, before March 1st in each year.

Before admission to the degrees of Bachelor of Medicine and Surgery candidates are required to send in the usual certificates of age and study as at the other Universities. All candidates for these degrees must pass three examinations, and must have attended courses of both lectures and laboratory work.

The final examination is divided into two parts, which may be passed separately or on the same occasion, but the first part cannot be taken before the end of the third year, and the second part cannot be taken less than two years after passing Second M.B., or before the fifth year of medical study in accordance with the University regulations. The subjects of examination are as follows: 1, Pharmacology and therapeutics; 2, General pathology and morbid anatomy; 3, Forensic medicine and toxicology and public health; 4, Obstetrics and diseases of women; 5, Surgery, systematic, clinical, and practical; 6, Medicine, systematic and clinical, including mental diseases and diseases of children. Candidates may select as a first part of the examination two or three of the subjects 1, 2, and 3.

The certificates required from candidates at the final examination are practically the same as for the corresponding examination at the London University, and only those who have previously passed the Second Examination are admitted to it. The regulations relating to the M.D. and Ch.M. degrees can be obtained on application to the Registrar.

Fees.—Matriculation examination, £2; for any subsequent examination, £1. First Examination, £5; for any subsequent examination, £2. The fees for the Second Examination, for the Final Examination, and for the examination for the degree of Ch.M. are the same as for the First Examination. A fee of £10 is payable on the conferring of the degree of M.D., a fee of £4 on the conferring of the degree of Ch.M.

The Matriculation Examination is held in June, in July (for schools), and about the end of September. The first M.B. and Ch.B. is held in June; also about the end of September. The Second and Final Examinations are held in March and July, the examination for Ch.M. in July only.

The medical school buildings, which include large laboratories, dissecting-rooms, library and reading-rooms, are on the most modern principles, and students wishing to engage in anatomical, physiological, or pathological research will find excellent opportunity for study in the complete and well-furnished laboratories. Hospital practice is taken out at the Royal Infirmary, which contains 300 beds. The Cheadle Lunatic Asylum, St. Mary's Hospital, the Southern Hospital, and other special hospitals also afford teaching facilities of great importance.

The appointments open to students are numerous and of considerable monetary value, and there are probably more here than are available at any other medical centre. The principal are:—Nine Entrance scholarships, the Leech fellowship of £100; Entrance scholarships in medicine, £100 (towards College and Infirmary fees); Manchester Grammar School scholarships, two or three of not less than £15 or more than £30 per annum for three years; Turner scholarship of £20 to students who have completed a course of medical study in the University; Platt physiological scholarships, two of the value of £50 each; Platt zoological and botanical scholarship, £50; Professor Tom Jones' memorial surgical scholarship of £100, awarded triennially; two Dauntsey medical entrance scholarships, value £35; John Henry Agnew scholarship in diseases of children, value £30, awarded annually; Graduate scholarship in medicine, £25 to £50, awarded annually; and many others.

Fees.—Composition fee, £80, in two sums of £40 each. Hospital practice: Composition fee, £42, or two instalments of £22 each.

Dental Fees.—Composition fee, £57 15s., payable in two sums of £28 17s. 6d. each. Hospital practice, £21.

BIRMINGHAM UNIVERSITY.

The University of Birmingham grants degrees of M.B., Ch.B., M.D., Ch.M., and also a B.Sc. in the subject of Public Health. As a rule, in order to obtain any of these degrees it is necessary that a student shall have passed at least the first four years of his curriculum in attendance upon the classes of the University, but the Senate has power of recognising attendance at another University as part of the attendance qualifying for these degrees.

Degrees of Bachelor of Medicine and Bachelor of Surgery.—The student must have passed either the Matriculation Examination of the University or one of the following examinations, which will be accepted in lieu thereof for the present:—(*a*) The previous examination of the University of Cambridge; (*b*) Responsions of the University of Oxford; (*c*) The matriculation examination of any other University in the United Kingdom; (*d*) The leaving certificate (higher) of the Oxford and Cambridge Boards; (*e*) The Oxford or Cambridge junior local examination (first or second class honours); (*f*) The Oxford or Cambridge senior local examination (honours); (*g*) The College of Preceptors examination for first-class certificate.

Matriculation Examinations are held in June and September each year.

Degrees of Doctor of Medicine and Master of Surgery.—At the end of one year from the date of having passed the Final M.B., Ch.B. Examination, the candidate will be eligible to present himself for the higher degrees of either Doctor of Medicine or Master of Surgery or both, the regulations for which may be had upon application to the Registrar. The University also grants a Degree and a Diploma in Public Health, and provides adequate instructions for the same.

Dental Department.—The University grants the Degrees of Bachelor and Master of Dental Surgery (B.D.S. and M.D.S.), and a Diploma in Dental Surgery (L.D.S.). The whole of the instruction for which may be taken out in the University, with which is associated the Birmingham Dental Hospital.

The General and Queen's Hospitals.—The practices of these hospitals are amalgamated for the purpose of clinical instruction under the direction of the Birmingham Clinical Board, by whom all schedules will be signed and all examinations conducted. The hospitals have a total of upwards of 400 beds. 6,000 in-patients and 80,000 out-patients are treated annually, and many valuable posts are open to students at both.

Further information can be obtained from Professor Gilbert Barling, Dean, Medical Faculty.

UNIVERSITY OF LIVERPOOL.

The Degrees in the Faculty of Medicine are Bachelor of Medicine and Bachelor of Surgery (M.B. and Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). The course of study for the degrees of Bachelor of Medicine and Bachelor of Surgery is of five years' duration, and of this period two years must be spent at the University, the remaining three years can be taken in any medical school approved by the University.

The University provides a complete curriculum for these Degrees, and possesses modern and well-equipped laboratories and class-tooms for the teaching of all the subjects.

For the Degree of M.D., a thesis is required which may be presented not earlier than one year after graduation, as M.B., Ch.B.

The degree of Ch.M. is given after a period of at least one year of further study after graduation as M.B., Ch.B., on the results of an examination.

The University also confers Diplomas in Public Health (D.P.H.) and Tropical Medicine (D.T.M.) upon qualified medical practitioners who have studied these subjects in the University and passed the prescribed examinations.

A Diploma (L.D.S.) and Degrees (B.D.S. and M.D.S.) have recently been instituted in dental surgery. These are only conferred upon students of the University. Particulars may be obtained from the Registrar.

Students may enter for the degrees of the University of Liverpool, or may study for the degrees and qualifications of the other licensing bodies.

Hospitals.—Students may take out their clinical work at the Liverpool Royal Infirmary, or at the United Hospitals Clinical School, which has been formed by the David Lewis Northern Hospital, the Royal Southern Hospital, and the Stanley Hospital. Particulars as to fees, appointments, &c., may be obtained from the Secretaries of these schools. The practice of the Lying-in, Eye and Ear, Women's, Children's, Dental, and Skin Hospitals is also open to students of the Faculty of Medicine.

Fellowships and Scholarships.—Fellowships, Scholarships, and Prizes of over £800 are awarded annually. A Holt Fellowship in Pathology and Surgery, of the value of £100 for one year, is awarded annually by the Medical Faculty to a senior student possessing a medical qualification. The successful candidate is required to devote a year to tutorial work and investigation in the Pathological department. A Holt Fellowship in Physiology, awarded under similar conditions, also of the value of £100 for one year. A Robert Gee Fellowship in Anatomy, awarded under similar conditions, of the value of £100 for one year. An Alexander Fellowship for Research in Pathology of the annual value of £100, renewable. A Johnson Colonial Fellowship in Pathology and Bacteriology (£100 a year, renewable). A John W. Garrett International Fellowship in Physiology and Pathology (£100 a year, renewable). An Ethel Boyce Fellowship in Gynæcological Pathology (£100 a year, renewable). A Stopford Taylor Fellowship (£100 a year, renewable) in Dermatological Pathology. A Thelwall Thomas Fellowship (£100 a year, renewable) in Surgical Pathology. Two Lyon Jones scholarships, of the value of £21 each for two years, are awarded annually—a Junior Scholarship, open at the end of the first year of study to Liverpool University students in the subjects of the first M.B. Examinations, and a Senior Scholarship, open to all students in the school at the end of the second or third year of study, in the subjects of Anatomy, Physiology, and Therapeutics. The Derby Exhibition of £15 for one year is awarded in Clinical Medicine and Surgery in alternate years. Students may compete in their fourth and fifth years. In 1904 the subject will be Clinical Medicine. The Torr Gold Medal in Anatomy, the George Holt Medal in Physiology, the Kanthack Medal in Pathology, and the Robert Gee Book Prize, of the value of £5, for Children's Diseases.

Entrance Scholarships.—Two Robert Gee Entrance Scholarships, of the annual value each of £25 for two years, are offered annually for competition. The holder is required to take out the Science Course for the University Degree in Medicine.

Communications should be addressed to the Dean, Professor Benjamin Moore, M.A., D.Sc., the University, Liverpool.

THE ENGLISH COLLEGES.

THE medical corporations in England are the Royal College of Physicians of London, the Royal College of Surgeons of England, and the Society of Apothecaries of London. The two Royal Colleges now co-operate to hold a series of examinations, on passing which the candidate receives the diploma of Licentiate of the Royal College of Physicians (L.R.C.P.), and Member of the Royal College of Surgeons (M.R.C.S.). The Society of Apothecaries grants a complete diploma in medicine, surgery, and midwifery.

Conjoint Examining Board in England.

Candidates for the above licences are required to complete five years of professional study at recognised medical schools and hospitals, after passing the preliminary examination, of which six months may be spent at an institution recognised by the Board for instruction in chemistry, or one year may be passed at an institution recognised by the Board for instruction in chemistry and biology, to comply with the following regulations and to pass the examinations hereinafter set forth.

Professional Examinations.—There are three examinations, each being partly written, partly oral, and partly practical. These examinations will be held in the months of January, April, July, and October, unless otherwise appointed, fourteen clear days' notice before the day on which the examination commences being required, the candidate transmitting at the same time the required certificates.

The subjects of the first professional examination are chemistry and physics, practical pharmacy, and elementary biology. A candidate is allowed to take this examination in three parts at different times. Rejection entails a delay of not less than three months from the date of rejection, and the candidate will be re-examined in the subject or subjects in which he has been rejected. If referred in chemistry or biology, he must produce evidence of further instruction at a recognised institution. Practical pharmacy may be passed at any time during the curriculum. Any candidate who shall produce satisfactory evidence of having passed an examination for a degree in medicine on any of the subjects of this examination conducted at a University in the United Kingdom, India, or in a British Colony, will be exempt from examination in those subjects in which he has passed.

The fees for admission to the first examination are as follows :—For the whole examination, £10 10s. ; for re-examination after rejection in Part I., £3 3s. ; and for re-examination in each of the other parts, £2 2s.

The subjects of the second examination are anatomy and physiology. Candidates will be required to pass in both subjects at one and the same time. Candidates will be admissible to the second examination at the expiration of two winter sessions and one summer session (or fifteen months during the ordinary sessions) from the date of registration as medical students, and after the lapse of not less than nine months from the date of passing Parts I. and III. of the first examination.

A candidate referred at the second examination will be required, before being admitted to re-examination, to produce a certificate that he has pursued, to the satisfaction of his teachers, in a recognised place of study, his anatomical and physiological studies during a period of not less than three months subsequently to the date of his reference.

The fees for admission to the second examinations are : £10 10s. for the whole examination, and £6 6s. for re-examination after rejection.

The subjects of the third and final examinations are : —Part I. Medicine, including medical anatomy, pathology, practical pharmacy, therapeutics, forensic medicine and public health. Candidates who have passed in practical pharmacy at the first examination will not be re-examined in that subject at the third examination. Part II. Surgery, including pathology, surgical anatomy, and the use of surgical appliances. Part III. Midwifery and gynæcology. Candidates may take this examination in three parts separately, or they may present themselves for the whole examination at one time.

Fees for admission to the third or final examination are as follows :—For the whole examination, £21 0s. Part I.—For re-examination in medicine, including medical anatomy, pathology, therapeutics, forensic medicine, and public health, £5 5s. ; for re-examination in practical pharmacy (if taken at this examination), £2 2s. Part II.—For re-examination in surgery, including pathology, surgical anatomy, and the use of surgical appliances, £5 5s. Part III.—For re-examination in midwifery and gynæcology, £3 3s.

A candidate referred on the third or final examination will not be admitted to re-examination until after the lapse of a period of not less than three months from the date of rejection, and will be required, before being admitted to re-examination, to produce a certificate, in regard to medicine and surgery, of having attended the medical and surgical practice, or the medical or surgical practice, as the case may be, during the period of his reference; and in regard to midwifery and diseases peculiar to women a certificate of having received, subsequently to the date of his reference, not less than three months' instruction in that subject by a recognised teacher.

Regulations for Colonial, Indian, and Foreign Candidates, and University Candidates.

Persons holding a Colonial, Indian, or a foreign qualification entitling them to practise medicine in the country of origin, and conferred after a course of study and examinations equivalent to those required by the Royal Colleges, are admissible to the second and third (final) examinations forthwith.

Members of a University in the United Kingdom are, under certain conditions, eligible for admission to the third (final) examination two years after passing at their University in the subjects included in the first and second examinations of the Board.

Royal College of Physicians of London.

Members.—The membership of the College is granted after examination to persons above the age of 25 years who do not engage in trade, do not dispense medicine, and do not practise in partnership. This diploma is only granted to persons already registered, or who have passed the final examination for the licence.

Medical graduates of a recognised University are admitted to a pass examination, but others must have passed the examinations required for the licence of the College. The examination, which is held in January, April, July, and October, is partly written and partly oral. It is directed to medicine, and is conducted by the president and censors. Candidates under 40, unless they have obtained a degree in arts in a British University, are examined in Latin, and either Greek, French, or German. Candidates over 40 are not so examined, and the examination in medicine may in their case be modified under conditions to be ascertained by application to the Registrar. The fee for the membership is £42, but if the candidate is a licentiate £15 5s. is deducted. In either case £6 6s. has to be paid before examination.

Royal College of Surgeons of England.

Membership.—The candidates are now subject to the regulations of the Conjoint Board.

Fellowship.—The Fellowship of the College of Surgeons is granted after examination to persons at least 25 years of age, who have been engaged in professional studies for six years. There are two examinations—the first in anatomy and physiology, which may be passed after the third winter session; the second chiefly directed to surgery, which may be passed after six years of professional study. The second examination may be passed before attaining the age of 25, but the diploma is not granted until that age is reached. Candidates for this part of the examination must have passed the final examination of the Conjoint Board in England, and have been admitted members of the College before they can be admitted thereto, except in the case of graduates in medicine and surgery of recognised Universities of not less than four years' standing.

Fees.—First examination, £5 5s.; second examination, £12 12s. The total fee payable on admission to the Fellowship is £31 10s., except for members, when the fee is £21. (The examination fees to the extent of £17 17s. count as part of the total fee.) Further information can be obtained on application to the Secretary of the Royal College of Surgeons, Lincoln's Inn Fields, London, W.C.

There are two examinations—primary and final. The primary examination is held quarterly on the first Wednesday, and on the Monday and Tuesday in the same week, in the months of January, April, July, and October. The final examination is held monthly.

Society of Apothecaries of London.

Primary Examination.—This examination consists of two parts: Part I.—Elementary biology, Chemistry, Chemical physics, including the elementary mechanics of solids and fluids; Heat, Light, and Electricity. Practical chemistry, Materia medica, and Pharmacy. A synopsis indicating the range of the subjects may be obtained on application. Part II.—Anatomy and Physiology and Histology. The examination is held in January, April, July, and October.

The final examination is held monthly, and is divided into Sections 1 and 2.

Section 1 consists of three parts.

Part I. includes: Principles and Practice of Surgery, Surgical Pathology, and Surgical Anatomy, Operative Manipulations, Instruments and Appliances.

Part II. includes: (*a*) The Principles and Practice of Medicine, including Therapeutics, Pharmacology, Pathology, and Morbid Histology. (*b*) Forensic Medicine, Hygiene, Theory and Practice of Vaccination; and Mental Diseases.

Candidates passing either (*a*) or (*b*) will not be re-examined therein.

Part III. includes: Midwifery, Gynæcology, and Diseases of New-born Children, Obstetric Instruments and Appliances. Candidates may enter for Parts I., II., and III. together or separately.

Section 1 of the Final Examination, or any part thereof, cannot be passed before the expiration of 45 months from the date of registration as a medical student.

Section 2.—This section consists of two parts:

Part I.—Clinical Surgery;

Part II.—Clinical Medicine and Medical Anatomy. Section 2 cannot be passed before the expiration of the fifth year.

Fees.—Primary examination, £5 5s.; final examination, £15 15s.; total fee, £21.

Further information, with particulars as to the course of study and of the certificates required, can be obtained from the Secretary to the Court of Examiners, Apothecaries' Hall, E.C.

This licence is a registrable diploma in Medicine, Surgery, and Midwifery, and qualifies the holder to compete for medical appointments in the Army, Navy, and Indian Services, also for Poor-law, Civil, and Colonial appointments.

The Gillson scholarship in Pathology of the annual value of £90, tenable for one year, is open to Licentiates of the Society and to candidates for the diploma who obtain it within six months of election to the scholarship. An examination in the art of prescribing is held annually, in January, at which the following prizes are awarded:—A gold medal of the value of £6; a silver medal, and a prize of books to the two best candidates.

LONDON SCHOOLS.

The Schools of Medicine in the Metropolis are the following, the scholarships, prizes, students' appointments, fees, &c., being set forth in connection with each place named. The names of the hospital staff, lecturers, residential terms, and detailed information will be found, as a rule, in our advertisement columns.

St. Bartholomew's Hospital.—This hospital has 750 beds, and for many years past the school attached has had a larger number of students than any other medical school in London. Laboratories have been specially equipped for the study of pathology, bacteriology, chemistry, biology, physics, and chemical pathology, and two additional operation theatres have just been built. A new block of buildings is in course of erection at a cost of £120,000, and will contain new casualty and out-patients' departments, eight special departments, quarters for the junior staff, a dining hall and a common room for students, &c.

Collegiate residence is permissible, subject to the ordinary rules.

Appointments.—Ten house physicians and ten house surgeons are appointed annually. During the first six months of office they act as "junior" house physicians and house surgeons, and receive a salary of £25 a year. During their second six months they become "senior" house physicians and house surgeons, and are provided with rooms by the hospital authorities, and receive a salary of £80 a year. A resident midwifery assistant and an ophthalmic house surgeon are appointed every six months, and are provided with rooms and receive a salary of £80 a year. Two assistant anæsthetists are appointed annually, and receive salaries of £120 and £100 a year respectively. An extern midwifery assistant is appointed every three months, and receives a salary of £80 a year. Chief assistants and clinical assistants are appointed in each of the special departments. In-patient dressers, in-patient clinical clerks, clerks, and dressers to the assistant physicians, and assistant surgeons, and to the physicians and surgeons in charge of special departments, are appointed every three months without fee.

Scholarships, &c.—There are four open scholarships in science, £75, £75, £150, £50, tenable for one year, and a Jeaffreson exhibition, value £20; at the end of first year four junior scholarships of £30, £20, £25, £15, respectively; Treasurer's prize for practical anatomy; Foster prize in practical anatomy; senior scholarship, value £50, for anatomy, physiology, and chemistry; Wix prize, Hichens prize, Lawrence scholarship and gold medal, value 40 guineas, for medicine, surgery, and midwifery; two Brackenbury scholarships, of £39, in medicine and surgery; Bentley prize, for reports of cases; the Kirkes gold medal for clinical medicine, with scholarship of £30. Shuter scholarship of £50; Skynner prize of £15; Sir G. Burrows' prize of £10; Matthews Duncan prize, medal and about £20; Willett medal and Walsham prize; Holden Research Scholarship in Surgery, value £105.

Fees.—By payment of an annual composition fee, a student is entitled to attend all the courses of instruction, and to hold the various clinical appointments. For students commencing their medical studies:—Entrance fee, 30 guineas; annual fee, 30 guineas, for five years, or a single payment of 165 guineas. A student on qualification at the end of the five years is not liable for any further fees, and receives a perpetual ticket. Should he fail to qualify in this time, the fee for further instruction is 10 guineas for each six months. Fees for University students:—Entrance fee, 20 guineas; 30 guineas, annually for two years, and 10 guineas for each six months if not qualified. Fees for preliminary scientific students:—20 guineas; for laboratory instruction for D.P.H., 15 guineas.

The Warden, Mr. W. D. Harmer, will furnish further details on application.

Charing Cross Hospital.—The school attached to this hospital is situated in central London, and contains new physiological, pathological, and bacteriological laboratories, materia medica and anatomical museums, an anatomical theatre, enlarged dissecting-room, and chemical theatre. Clinical instruction is given in medicine, surgery, and obstetrics, and in the special department, diseases of the skin, diseases of children, mental disorders, the throat, the eye, nose and ear, and in the orthopædic, Röntgen, and electrical departments, there are several scholarships and prizes, particulars of which can be obtained of the Dean.

Appointments.—The curator and pathologist is appointed annually, and receives £100 a year; medical and surgical registrars to the hospital receive £40 a year each, with luncheon in the hospital; obstetric registrar, six house physicians, six house surgeons, and two resident obstetrical officers are appointed each year; clinical clerks and dressers are appointed in all the general and special departments of the hospital.

Fees.—For the curriculum of study required by the various examining bodies and hospital practice, 115 guineas in one sum, or 126 guineas in five instalments.

The composition fee for sons of registered medical practitioners is 105 guineas, and the fee, by instalments, 115 guineas. For dental students, 55 guineas in one sum, or 61 guineas payable in two instalments of 31 and 30 guineas respectively.

St. George's Hospital.—This hospital is situated in the West End, facing Hyde Park. It contains 351 beds, and special wards for ophthalmic cases and diseases of women.

Appointments.—Eight house physicians and eight house surgeons, entitled to reside and board in the hospital free of expense; twelve general assistants, six assistants in the special departments. Candidates for the above offices are selected quarterly by competition from among the perpetual pupils, sixteen pupils being in office at any one time. Obstetric assistant with a yearly salary at the rate of £50 and board and residence in the hospital; curator of the museum with a salary of £200; assistant curator with a salary of £100; two medical registrars, with salaries of £200 per annum; a surgical registrar with a salary of £200 per annum; an administrator of anæsthetics with a salary of £50 and two with salaries of £30 per annum; a surgery officer with a salary of £100 a year; two or more demonstrators of anatomy with a salary of £50 each; and assistant demonstrators. All offices are open to candidates without additional fee.

There are various scholarships and exhibitions open to students, particulars of which will be furnished by the Dean.

Fees.—Entrance fee, 20 guineas; annual composition fee, 30 guineas; prel. sci. fee, 16 guineas, with an additional 4 guineas for expenses. In the event of study for the preliminary scientific or corresponding examinations being carried out at this school, the fee of 16 guineas will be regarded as part of the entrance fee. Entrance fee for University students, 10 guineas.

Guy's Hospital.—This hospital is situated on the Surrey side of London Bridge, and contains 602 beds in constant occupation. There are special wards for ophthalmic and obstetric cases, eight beds in the latter being appropriated for difficult cases of labour. Some beds have also been set apart for diseases of the ear and throat, and an "isolation" ward for cases of infectious diseases arising in the hospital has been constructed. An obstetric registrar and tutor and an ophthalmic registrar and tutor are appointed to augment the teaching in the special departments, in addition to those attached to the general surgical and medical wards. Attached to the hospital is a large residential college with rooms for about sixty men, whilst for students who prefer to live in the suburbs, no other hospital is so conveniently placed, the railway accommodation being good and close at hand. There is a complete School of Dental Surgery at this Institution, which is recognised by the Royal College of Surgeons of England; the facilities thus afforded of completing the whole course of dental study within the walls of one hospital will be appreciated by those intending to practise dentistry. A new museum for pathological specimens and additional lecture and class rooms were opened this year.

Appointments.—Eight house surgeons, eight house physicians, eight assistant house physicians, twenty-four assistant house surgeons, eight obstetric residents, two ophthalmic house surgeons, twenty-four clinical assistants, and ninety-six dressers are selected annually from the students according to merit, and without payment. There are also a large number of junior appointments, every part of the hospital practice being systematically employed for instruction.

Scholarships.—Open scholarships of £100 and £50 in classics, mathematics, and modern languages. Open scholarships of £150 and £60 in chemistry, physics, and biology, and an open scholarship of £50 for University students in two of the following subjects:—Anatomy, physiology, organic chemistry, zoology, physics. The following are the scholarships, prizes, and medals open to students of the hospital:—The Arthur Durham prizes for dissection, £15 and £5; Junior prizes for general proficiency, £20, £15, £10; Hilton prize for dissection, £5; Michael Harris prize for anatomy, £10; Sands Cox scholarship for physiology, £15; Wooldridge prize for physiology, £10; Beaney prize in pathology, £34; Golding-Bird prize in bacteriology, gold medal and £20; Treasurer's gold medal in clinical medicine; Treasurer's gold medal in clinical surgery; Beaney studentship in materia medica (tenable for 3 years), annually £31 10s.; Gull studentship in pathology (tenable for 3 or 5 years), annually £150.

Fees.—A new system for payment of composition fees has been recently instituted at this school. Particulars may be obtained on application to the Dean, Guy's Hospital, London Bridge, S.E.

King's College Hospital.—This hospital is centrally situated, being contiguous to the Royal College of Surgeons, Lincoln's Inn Fields. The College adjoins Somerset House and is close to the hospital, in which there are 220 beds available for clinical teaching; ophthalmic, ear, throat, skin, and dental departments are attached to the hospital. Some wards are specially devoted to children's diseases. The wards have been recently refloored and the electric light is installed throughout.

Scholarships.—Two scholarships of the value of £100 each; a scholarship, value £50, is open to students of a British University who come up to London to complete their curriculum, ; and one of £40 for fifth year students. In addition, students may compete for the Carter, Todd, Tanner prizes, and all class and clinical prizes.

Appointments.—Medical and surgical Sambrooke registrarships, tenable for two years, each £50 per annum. Resident hospital appointments, *viz.*, senior and junior house physicians, assistant house physician, physician accoucheur's assistant and assistant house accoucheur, and three house surgeons with free board and residence at the hospital; and senior and junior clinical assistants in special departments.

Special courses of lectures and practical instruction; the chemical, physical, physiological, and other laboratories have been arranged for students preparing for preliminary scientific, intermediate, science and other examinations of the University of London.

F.R.C.S. Examinations.—Special classes are arranged for the final F.R.C.S. examinations. Further particulars can be obtained from the Dean.

London Hospital.—This hospital is the largest in Great Britain, containing, as it does, 927 beds. It has, moreover wards and a teaching staff for almost every special department in the domain of medicine; the scholarships and prizes are many and valuable.

The additional buildings for the department of public health, for the biological, chemical, and physical laboratories, materia medica museum, &c., and the new bacteriological department with general laboratory, research laboratories and class rooms for D.P.H. work are now open.

Appointments.—The "House" appointments, which are numerous, are made without fee of any kind, and all resident officers are provided with free board and rooms, and in some instances with salary also.

Fees.—Perpetual fee for lectures, demonstrations and hospital practice, payable in three instalments of 45, 45, and 40 guineas at the commencement of the first, second, and third years respectively, 130 guineas; or, if in one payment, 120 guineas. Fee for students entering in their third year (their first and second years having been spent at a recognised medical school elsewhere), 60 guineas. This fee is payable by students entering who have passed the first M.B. Oxford; the second M.B. Cambridge; or the Intermediate M.B. London. Dental students (general hospital practice and lectures), 40 guineas. General fee for dental practice, 10 guineas.

Note.—A reduction of 15 guineas will be allowed to the sons of medical men from the perpetual fee if paid in full, or 5 guineas from each instalment.

Special entries can be made either for single courses of lectures or for hospital practice. Residential accommodation is obtainable at a very reasonable rate close by, or in the suburbs a few minutes' distant by train. Fuller particulars can be obtained of the Warden, Mr. Munro Scott.

St. Mary's Hospital.—This hospital is situated at Paddington, near the terminus of the Great Western Railway, and at present contains 281 beds. The new wing, the ground-floor of which, comprising the new out-patient department, was opened in 1898, is now completed, and will be opened as soon as funds will permit; this will raise the number of beds to 350, and will include additional operating theatres, a new clinical laboratory, a clinical theatre, and an X-ray department. An athletic ground has recently been acquired for the use of students at North Kensington (20 minutes from the hospital), and will be available for football, cricket, and lawn tennis during the coming sessions.

Appointments.—All clinical appointments in the hospital are free to students of the Medical School, and the resident medical officers are chosen by competitive examination. Six house physicians, six house surgeons, four obstetric officers, and two resident anæsthetists are appointed in each year, and receive board and residence in the Hospital.

Scholarships, &c.—One scholarship in natural science, of the value of £145, open to any gentleman who has not completed a winter session of study at a medical school. One scholarship in natural science, of the value of £78 15s., and two of £52 10s., under the same conditions. Two scholarships, each of 60 guineas, open to students from any British University. The scholarships will be awarded by examination on September 25th, 26th, and 27th.

Fees.—Fee for attendance on the full five years' curriculum of hospital practice and all lectures, demonstrations, and special tutorial classes, £140, paid in one sum on entering the school; or in instalments, £145.

Students who have completed their examinations in anatomy and physiology at the Universities of Oxford, Cambridge, or other University, are admitted as perpetual pupils on payment of a fee of 60 guineas in one sum, or 65 guineas in two annual instalments. University students, prior to completing the anatomy and physiology examinations, pay an annual fee of 25 guineas. After completing the anatomy and physiology examinations, the inclusive fee may be paid.

Preliminary Scientific Course.—A complete course of instruction in chemistry, physics, and biology, recognised by the University of London, as an approved course for internal students, is held throughout the year. Students may join in October, January, or May.

Middlesex Hospital.—This hospital, which is conveniently situated in the centre both of business and residential London, contains 340 beds. There are special departments for cancer, and for ophthalmic, throat, aural, skin, dental, children's diseases, and electrical treatment (X-ray and Finsen light). Wards are also devoted to cases of uterine disease. The new school buildings are now in regular use. Residence for students is obtainable in the residential college, which has its frontage on the hospital garden.

Appointments.—Casualty surgical officer, casualty medical officer, six house surgeons, six house physicians, and two resident obstetric physicians. The above officers have residence and board in the college free of expense. Clinical clerks and dressers in all the departments are also appointed in addition to the foregoing.

Scholarships, &c.—Two entrance scholarships of the value of £100 and £60 respectively. One entrance scholarship of the value of £60, open to Oxford and Cambridge students only. (Subjects—Anatomy and physiology, including histology.) "Emden" Cancer Research Scholarship, £100. "Richard Hollins," Research Scholarship, £105. Two Broderip scholarships of £60 and £40 respectively, for medicine and surgery; John Murray medal and scholarship, awarded every third year; the Governor's prize of £21 for students in their final year. Hetley clinical prize, value £25, awarded annually for proficiency in practical clinical medicine, surgery, and obstetrics; the Lyell Gold Medal and scholarship, value £50, in surgery and surgical anatomy; the Leopold Hudson prize, value 11 guineas, in surgical pathology, including bacteriology; Freeman scholarship, £30, in obstetrics and gynæcology; exhibitions of 10 guineas and 5 guineas for anatomy and physiology to second and first year's students respectively, as well as class prizes in all subjects.

Fees.—General fee for the entire course of hospital practice and lectures, 135 guineas, if paid in one sum on entrance, or by instalments of 60, 50, and 35 guineas, payable at the commencement of the first, second, and third years respectively. For those who have completed their anatomical and physiological studies the fee is 70 guineas on entrance, or in two instalments of 40 and 35 guineas. The composition fee for London University students is 145 guineas. For those who have passed the preliminary science examination 120 guineas. The fee for the curriculum for dental students is 54 guineas on entrance, or two instalments of 40 guineas and 20 guineas.

St. Thomas's Hospital.—This hospital, with medical school attached, is situated on the southern Embankment of the Thames, facing the Houses of Parliament and contains 602 beds, in constant use. The school buildings, which are separated from the hospital by a quadrangle, comprise numerous theatres, laboratories, and class rooms, which are well adapted for the modern teaching of large bodies of students in all subjects of the medical curriculum. There is a large library and reading-room, and a very complete museum and gymnasium.

Appointments are open to all students. A resident assistant physician and a resident assistant surgeon are appointed annually at a salary of £100 with board and lodging; two resident casualty officers at a salary of £100 per annum. Two hospital registrars, at an annual salary of £100 each, are appointed yearly. The tenure of these offices may be renewed for a term not exceeding two years. An obstetric tutor and registrar is appointed each year at an annual salary of £50. Four house physicians, two house physicians to out-patients, four house surgeons, four house surgeons to out-patients, two obstetric house physicians, two ophthalmic house surgeons, and eight clinical assistants in the special departments are appointed every three months.

Scholarships, Prizes, &c.—Three entrance scholarships are offered for competition in September, *viz.*, one of £150 and one of £60 in chemistry, physics, and biology at the commencement of the second year; one of £50 open to University students who have passed in anatomy and physiology, for a medical degree in any of the Universities of the United Kingdom, and have not entered as students in any London Medical school. Numerous scholarships, prizes, and medals are open to competition throughout the whole career of a student, including a Fellowship of £100 given by the Salters' Company for research in pharmacology, and the Louis Jenner research scholarship, £60, for pathological research.

Special courses of instruction for the Preliminary Scientific and Intermed., M.B.Lond., for the Oxford and Cambridge examinations, and for the Primary and Final F.R.C.S. are held throughout the year.

A register of approved lodgings is kept by the medical secretary, who has a list of local medical practitioners and others who receive students into their houses. The prospectus of the school may be obtained on application to Mr. G. Q. Roberts, Secretary of the Medical School.

University College and Hospital.—The hospital with college opposite, are situated in Gower Street, not far from Euston railway terminus. The number of beds available for teaching purposes is 277.

Appointments.—Eight house physicians, six house surgeons, four senior and four junior obstetric assistants, and two ophthalmic assistants are selected annually by examination from among the senior students, without fee. The house physicians and house surgeons reside in the hospital for a period of six months, and the senior obstetric assistants for three months, and receive their board and lodging free.

The offices of out-patient physicians' and surgeons' assistants, clinical clerks, surgeons' dressers, and ophthalmic surgeons' assistants are filled by pupils who are also students of the college, without additional fee.

Scholarships, &c.—Entrance scholarships (examination begins on September 26th, at 10 o'clock): One of the value of £120, and two of 60 guineas for proficiency in science, the subjects being those of the Preliminary Scientific Examination of the University of London, and two of 80 guineas each, the subjects being anatomy and physiology; the Atkinson-Morley surgical scholarship of £45 a year, tenable for three years; Atchison's scholarship, value £55, tenable for two years; Sharpey physiological scholarship, value about £105 a year; Filliter exhibition for proficiency in pathological anatomy, value £30; Erichsen prize, operating case, value £10 10s., awarded for practical surgery, Dr. Fellowes' clinical medals, the Liston gold medal, Alexander Bruce gold medal, Cluff memorial prize, Tuke medals for pathology, class medals, &c., gold and silver medals or other prizes, as well as certificates of honour, are awarded after competitive examinations in particular branches of study. The Tuffnell scholarship of £80 for chemistry, two years; and the Clothworkers' exhibitions in chemistry and physics of £30 each, can also be held in the medical faculty.

Composition Fees.—The following have been grouped to meet the requirements of the various examining boards: A.—For the Courses required by the University of London. 1. For the Preliminary Scientific course: 25 guineas, entitling to one attendance. 2. For the Intermediate Course: 60 guineas, if paid in one sum; 62 guineas if paid in two instalments. 3. For the Final M.B., B.S. Course: 80 guineas, if paid in one sum; 82 guineas, if paid in two instalments. This course of instruction is also suitable for the corresponding examinations at the Universities of Oxford, Cambridge, and Durham.

B.—For the Medical education required by the Examining Board in England and the Society of Apothecaries: 4. For the Course required for the First Examination: *30 guineas entitling to one attendance. 5. For the Second: 50 guineas, if paid in one sum; 51 guineas, if paid in two instalments. 6. For the Course required for the Third Examination: 80 guineas, if paid in one sum; 82 guineas, if paid in two instalments.

The composition fee in each case entitles to attendance on Lectures and Hospital Practice during three years.

C.—For Dental Students. Composition fee for the Courses required for the L.D.S., 65 guineas; or exclusive of chemistry, practical chemistry, physics, and materia medica, 50 guineas.

Students may repeat attendance at the Courses in chemistry and physics for £3 3s. (inclusive) and in elementary biology for £2 2s.

Westminster Hospital.—This hospital is conveniently situated, facing the Abbey, and is readily accessible from all parts of the Metropolis. It contains 205 beds for general cases, and all the special departments. New school buildings have been erected close by which afford accommodation for 150 students. The class rooms, dissecting rooms, and lecture theatre are excellent samples of modern erections, affording ample scope for study.

Appointments.—Medical and surgical registrars, each £50 per annum; two house physicians, three house surgeons, one assistant house physician, one assistant house surgeon, and a resident obstetric assistant. These officers, except the two first named, are all boarded free of expense. Fourth year's students are appointed to be clinical assistants in the various departments.

Scholarships, &c.—(*a*) Winter Session—The Guthrie scholarship £60, entrance scholarship £40, entrance scholarship £30, dental scholarship £20; subjects, Latin, mathematics, experimental physics, chemistry, and either Greek, French, or German. University scholarships, £40 and £30; subjects, anatomy and physiology. Natural science scholarship, £60, same as for Prel. Sci. of University of London. Natural science scholarship, £40, chemistry and physics. Free presentation, open to pupils of Epsom Medical College. (*b*) Summer Session.—Natural science scholarship, £60, same as winter. Natural science scholarship, £40, same as above. Arts scholarship, £60, arts scholarship, £40, University scholarships, £40 and £30, subjects same as in winter session. (*c*) Prizes, to be competed for by unqualified men. Chadwick, 20 guineas for students of any year not exceeding fifth. Bird medal and prize, £14 for students who have completed fourth winter session. Sturges prize in clinical medicine, £8, clinical surgery prize, £5. And class prizes in the various subjects.

Fees.—(*a*) For course required by Conjoint Board, In one payment of 110 guineas, or two payments of 60 guineas each, payable on entrance and at the commencement of second year respectively, or by six payments distributed over six sessions of 25 guineas and 20 guineas alternately. (*b*) For the entire course of the University of London the composition fee is 133 guineas. Fees for shorter periods or for single courses may be learned on application to the Dean. Fees for dental students, payable in one sum on entrance, 50 guineas, or in two instalments, of £27 10s.

London School of Medicine for Women (Royal Free Hospital).—The school is situated in Hunter Street, Brunswick Square, W.C., and the Royal Free Hospital is in Gray's Inn Road, close to the School. The school was re-built in 1893, and the laboratories are fully equipped for all the work required for the preliminary scientific and intermediate M.B. examinations of the University of London. A course of study is specially arranged for the work required by the Conjoint Colleges of Scotland and the Society of Apothecaries. Students are also prepared for the examinations of the University of Durham and other Universities. The Royal Free Hospital contains 165 beds available for clinical study; and there is a large out-patient and casualty department. In addition to the ordinary systematic lectures at the school, clinical lectures are given at the hospital in medicine, surgery, obstetrics, ophthalmology and dermatology. Students hold clerkships and dresserships in each department.

Appointments.—Two house physicians, two house surgeons and a senior and junior resident obstetric assistant are appointed yearly. There are also many non-resident appointments including the anæsthetist and assistant anæsthetists, assistant and clinical pathologists, medical and surgical registrars, curator of museum and clinical assistants.

Scholarships.—A school scholarship of £30, and a St. Dunstan's medical exhibition of £60 yearly for three years, extendible to five years, are offered annually. In addition to these there are various scholarships and prizes offered from time to time, including the Bostock scholarship of £60 a year for two years, extendible to four years; two Mackay prizes of £20 each; the Stuart Mill scholarship of £30 a year for four years; the John Brown Bursary of £20 a year; and the Mabel Webb research scholarship of £30 a year.

Fees.—The fee for the intermediate and final M.B. University of London course is £135 in one sum, or £145 in the following instalments:—first year, £45; second year, £40; third year, £40; fourth year, £20. The fee for the preliminary science classes is £25. The fee for the course for the Conjoint Colleges or Society of Apothecaries, including elementary science, is £140 in one sum, or in the following instalments:—first year, £50; second year, £40; third year, 8£40; fourth year, £20. Further particulars can be obtained from the Secretary, Miss Dowise, M.B., 8, Hunter Street, W.C.

EXTRA-ACADEMICAL INSTITUTIONS IN LONDON.

The Royal Dental Hospital.—The teaching and hospital practice at this institution (situated in Leicester Square) are recognised by the various examining bodies. The new hospital was opened in March, 1901, and is complete in every detail with modern appliances, and the school is the most thoroughly equipped of any in the United Kingdom. The clinic of the hospital is unrivalled, no less than 90,458 cases being treated in 1904. The following scholarships and prizes are open to all full term students:—Entrance scholarship, of the value of £20, awarded in October. Subjects: Chemistry and dental mechanics. Saunders scholarship, of the value of £20, awarded to the student obtaining the highest aggregate number of marks. Storer-Bennet research scholarship of the value of £51, awarded once in three years. Robert Woodhouse prize, of the value of £10, for practical dental surgery. Class prizes are awarded by the various lecturers.

Provision is made for teaching mechanical dentistry as required by the Royal College of Surgeons, the pupils being under the guidance of the staff of dental surgeons assisted by specially appointed demonstrators.

The school contains an excellent library and a well-arranged museum.

Fees.—For the two years' hospital practice and lectures as required by the Royal College of Surgeons of England, the fee is £53 3s. in one instalment, or £55 13s. in two yearly instalments. The fee for the complete curriculum, namely, three years' instruction in mechanical dentistry and two years' hospital practice and lectures, is £175 if paid in one instalment, or 175 guineas if paid in three instalments of 75 guineas in the first year, and 50 guineas each in the second and third years. For one year's instruction in mechanical dentistry the fee is 50 guineas. The necessary course of two years at a general hospital can be taken simultaneously with that at the Royal Dental Hospital. Further particulars can be obtained on application to the Dean.

National Dental Hospital.—This institution is centrally situated (Great Portland Street, W.), and excellent teaching facilities and hospital practice are here obtainable, special demonstrations being given by members of the staff. There are also a mechanical laboratory, bacteriological laboratory, museum, students' common room, a metallurgical laboratory, extraction and stopping rooms, lecture hall, regulations room, &c., all lighted by electricity, and warmed and ventilated after the most approved requirements; in fact, this institution may be pronounced a model dental hospital and school. The winter session commences at the same time as at the medical schools, on October 2nd. The medical tutors hold special classes before each college examination. The prizes include two entrance exhibitions, value £40 and £20, and the Rymer prize of £5 5s., the examinations for which are held in May and October. The fee for two years' hospital practice required by the curriculum, including lectures, is £40. (See advt.)

London School of Tropical Medicine (University of London).—This Institution is the outcome of a suggestion by the Right Hon. Joseph Chamberlain, H.M. late Secretary of State for the Colonies, and is situated at the Royal Victoria Docks, in connection with the Seamen's Hospital, than which no more suitable spot could be found, as ships arrive there in great numbers from the Tropics, affording immediate opportunity for the study of tropical diseases. The school buildings are placed within the hospital grounds, and systematic courses of instruction are obtainable from duly authorised teachers throughout the year. Students also have the privilege of attending the medical and surgical practice at the "Dreadnought" Hospital, Greenwich, Information as to fees, &c., can be obtained of the Dean or the Secretary.

Medical students are admitted to the practice of the following Metropolitan hospitals to which no medical school is attached. Detailed particulars will be supplied on application to the various secretaries.

West London Hospital, Hammersmith. — This contains 175 beds, and has an extensive out-patient department. Dresserships and clinical clerkships may be obtained. Two house surgeons and two house physicians are selected every six months. There are special departments for diseases of the throat, nose and ear, skin, women and children, and deformities. Electrical and X-ray departments have also been added. The practice of this hospital is reserved exclusively for medical men, junior students not being admitted.

Great Northern Central Hospital, Holloway Road, N.—This institution has been greatly enlarged, contains 167 beds, cases in various special departments are treated, and the hospital is now recognised for study during the fifth year by the Conjoint Board. The practice of the hospital is open to practitioners and senior students, and clinical and pathological assistants are appointed in the wards and out-patient departments, as in the larger general hospitals.

Bethlem Royal Hospital.—In this Royal institution only cases of lunacy are received, and students intending to pursue this special branch have the best possible opportunities afforded here. The hospital contains 300 beds, and two resident house physicians who have recently obtained their diplomas to practise medicine and surgery are elected every six months, and are provided with apartments, complete board, attendance, washing, and an honorarium of 25 guineas per quarter. The students of certain specified London medical schools receive clinical instruction in the wards of the hospital, and qualified practitioners may attend for a period of three months on payment of a fee. Post-graduate lectures are also given.

National Hospital for Epilepsy and other Diseases of the Nervous System, Queen's Square, W.C., contains 200 beds. It has on its staff men of European reputation, and the institution is recognised by the Conjoint Board where part of the fifth year of study may be devoted to clinical work. Clinical clerks are appointed to the physicians for out-patients, and courses of lectures and clinical demonstrations are given each year.

London Temperance Hospital.—The hospital contains 110 beds, and is conducted as its name implies on non-alcoholic principles by an excellent staff. The medical and surgical practice is open to students and practitioners. Appointments (vacancies for which are advertised in the medical journals): Surgical and medical registrars, resident medical officer, and one assistant resident medical officer.

Metropolitan Hospital, Kingsland.—This was until recently known as the Metropolitan Free Hospital, is situated in the north-eastern district of the Metropolis, and contains 160 beds. It is a general hospital, with various special departments for the treatment of diseases of the eye, throat, ear, &c.

Tottenham Hospital, N.—This hospital contains medical and surgical wards and a ward for children, having in all 73 beds. There are special departments for gynæcological cases, diseases of the eye, ear, throat and nose, and skin diseases. It has now been authorised by the University of London to give certificates of post-graduate study for the M.D. and M.S. degrees.

Hospitals for Consumption.

Hospital for Consumption and Diseases of the Chest, Brompton.—The largest institution for the treatment of affections of the chest in the United Kingdom, there being 321 beds in the two buildings. There are four house physicians who reside in the hospital, each for a period of six months. Lectures and demonstrations are given by members of the medical staff on Wednesdays and Fridays at four o'clock, save during the vacations. Terms, £2 2s. for three months; £5 5s. perpetual. This hospital is recognised by the Conjoint Board, the University of London, and the Apothecaries' Society.

Mount Vernon Hospital, Hampstead and Northwood.—This institution, formerly called the North London Consumption Hospital, now carries on its work at Hampstead with 145 beds, and at Northwood with 100 additional beds, where treatment is carried out on the most modern lines, including the "open air" and other systems. Students are admitted to the practice of the hospital under certain conditions, and post-graduate courses are regularly delivered during the year.

City of London Hospital for Diseases of the Chest, Victoria Park.—This is a large and well-equipped hospital at the East End, containing 164 beds. Clinical lectures and demonstrations are given by the members of an exceptionally experienced staff. Fee for three months' attendance on hospital practice, 2 guineas; six months, 3 guineas.

Royal Hospital for Diseases of the Chest, City Road.—(80 beds.)—This hospital has been enlarged by the addition of a very complete out-patients' department, and also by the erection of a new wing, which provides accommodation for 80 in-patients.

Throat and Ear Hospitals.

Central London Throat and Ear Hospital, Gray's Inn Road.—In addition to the in-patient department, which is now undergoing enlargement by the addition of more beds and an operating theatre, there is an extensive out-patient department in which clinical demonstrations are given daily during the hours of the surgeons' visits. Full facilities are afforded for acquiring sound practical experience of the subjects. Twelve clinical assistants, who must be duly qualified, are elected to assist the surgeons. Operation days—Tuesdays and Fridays, 2 p.m. Fees for the three months' attendance, £3 3s.; six months', £5 5s. Full details of this institution and post-graduate work will be found on reference to our advertising columns or on application to the Dean.

Hospital for Diseases of the Throat, Golden Square, W.—This hospital has been recently rebuilt and contains 50 beds. Clinical instruction is given daily in the Out-patient Department on diseases of the nose, throat, and ear. There are nine clinics weekly, and an annual out-patient attendance of nearly 50,000. Major and minor operations daily (Mondays excepted) in different theatres. Four senior and forty-two junior clinical assistants are appointed from among the students to assist the surgeons. Students are admitted to the practice of the hospital at the following fees:—Three months, £5 5s.; six months, £7 7s.; perpetual attendance, £10 10s. Further details can be had by applying to the Dean.

Metropolitan Ear, Nose, and Throat Hospital.—The hospital was founded in 1838, and is situated in Grafton Street, Tottenham Court Road. The out-patient department is open daily at 2.30 p.m. to practitioners and students for acquiring clinical instruction and technical knowledge. Operations are performed on in-patients on Tuesdays, Wednesdays, and Thursdays at 9 a.m. Fee for one month's attendance at the hospital one guinea, and for three months two guineas. During the forthcoming session demonstrations will be given by members of the staff on the pathology and treatment of diseases of the ear and respiratory passages. Short practical classes will also be held in clinical pathology and surgical anatomy. Weekly clinical lectures are given by the staff on the special disease treated at the hospital.

Women and Children.

The Hospital for Women, Soho Square.—The hospital contains 61 beds. In connection with this institution there is now an organised school of gynæcology open to qualified medical men and to students after their third year. Clinical assistants to the physicians and surgeons in the in-patient and out-patient departments are appointed every three months. Fee for the three months' course, and certificate, £8 8s.

The Samaritan Free Hospital for Women and Children, Lower Seymour Street, W., offers excellent opportunities for clinical study and training in the details of operative gynæcology. The success of the staff in this department has gained for them a European reputation. There are 47 beds

Royal Waterloo Hospital for Children and

Women.—This important institution, situate in South London, has been in a transition state for some time past, having been partly rebuilt and appointed on ambitious lines, and when completed, which it is expected to be shortly, will contain 200 beds.

Hospital for Sick Children in Great Ormond Street, Bloomsbury, W.C., and Cromwell House, Highgate.—Fee for three months' attendance, £2 2s.; perpetual, £3 3s. There are now 200 beds, besides 52 additional at the convalescent branch, and it is probably the largest institution of the kind in the world. The practice of the hospital is open to pupils of the different hospitals and medical schools of London and medical practitioners on conditions to be ascertained from the Secretary.

Eye Hospitals.

Royal London Ophthalmic Hospital, formerly in Moorfields, and recently rebuilt in the City Road, is the largest hospital devoted to this specialty in Great Britain, and contains 138 beds. Students and practitioners are admitted to the practice daily at 9 o'clock. Operations, 10 o'clock and after. Fee for six months, £3 3s.; perpetual, £5 5s. Further particulars of the Secretary.

Royal Westminster Ophthalmic Hospital, adjoins Charing Cross Hospital in King William Street. It has about 40 beds and a very large out-patient *clinique.* The lectures and demonstrations are arranged with special reference to the requirements of practitioners and senior students. Fee, six months, £3 3s.; perpetual, £5 5s.

Royal Eye Hospital, St. George's Circus, Southwark.—There are 40 beds and two cots. Fees, £2 2s. for three months, £3 3s. for six months, and £5 5s. perpetual. Courses are held on ophthalmoscopy, refraction, and diseases of the eye; fee, £1 1s. for each course, but perpetual students may attend each course once without extra fee. Pathology class, £1 1s. extra to cover cost of materials.

Skin Hospitals.

St. John's Hospital for Diseases of the Skin.—Out-patient department, Leicester Square; In-patient department, Uxbridge Road, W. This hospital has a well-equipped in-patient department, with 50 beds. It has a School of Dermatology at 49 Leicester Square, which is conducted by the medical staff of the hospital. During the past year the free course of Chesterfield Lectures given by Dr. Morgan Dockrell has proved a great success, being well attended by the profession. The next course (free) will commence on Thursday, October 5th, at 6 p.m., in the Lecture Room of the Hospital, Leicester Square. The Out-patient Department has just been rebuilt at a cost of £10,000, and contains a spacious laboratory and lecture and special department for X-rays, high frequency, and Finsen treatment. (See Advt.)

One of the oldest institutions of the kind is the Western Skin Hospital (Great Portland Street), which was started as long ago as 1851. The practice of the hospital is open to students and practitioners. Students of this specialty have also the London Skin Hospital, in Fitzroy Square, with seven beds and an out-patient department of over 1,400. There is also the Stamford Street Skin Hospital, in the southern part of the Metropolis, with 10 beds and an out-patient department of 5,600, so that the students' needs in this direction are well catered for.

METROPOLITAN POST-GRADUATE INSTITUTIONS.

Medical Graduates' College and Polyclinic.—This institution affords to medical men special facilities for acquiring technical skill, and advancing their medical and scientific knowledge. The building, which is large and commodious, is situated in Chenies Street, Gower Street, and contains lecture and consulting rooms, pathological and clinical laboratories, Röntgen ray room, an ophthalmoscope room, a library and museum, and reading and smoking rooms. *Cliniques,* at which patients are shown, are given every day of the week except Saturday, at 4 p.m. Lectures on Medicine, Surgery, and other allied subjects are delivered on Mondays, Tuesdays, Wednesdays, and Thursdays at 5.15 p.m. Four sessions of practical classes, each lasting six weeks, and a vacation session of three weeks' duration, are held during the year, the subjects taught comprising ophthalmology, otology, clinical microscopy, laryngology, urinary analysis, gynæcology, applied anatomy, nervous diseases, and practical X-ray work. There are, in addition, extra-mural classes in operative surgery, bacteriology, and public health.

A complimentary ticket for three days, admitting to *cliniques* and lectures, is issued to any medical practitioner on personal application at the college. The annual subscription for medical practitioners of either sex, holding qualifications granted in any of H.M.'s dominions—wherever resident—is One Guinea. Full information may be obtained from the medical superintendent, Mr. Hayward Pinch, F.R.C.S.

West London Post-Graduate College.—The West London Hospital, Hammersmith Road, W., contains 159 beds; the post-graduate course was started in 1895, and this is the only post-graduate college in London attached to a general hospital. Instruction is given in the out-patient department daily at 2.15 p.m. by the assistant physicians and assistant surgeons. The physicians and surgeons attend daily at 2.30 p.m., when post-graduates can accompany them in their visits to the wards. Operations are performed daily at 2.30 p.m. There are lectures every evening at 5 p.m. (Saturdays excepted).

Fees.—The fee for the hospital practice including all the ordinary lectures and demonstrations, is £1 1s. for one week; £2 2s. for one month; £5 5s. for three months; £8 8s. for six months; £12 12s. for one year, and £25 for a life ticket. A course of attendance on either the medical or surgical practice alone may be taken out for the fee of £3 3s. for three months. The fee for three months' attendance in any one special department, other than medicine or surgery is £2 2s. A prospectus containing full particulars will be forwarded on application to Mr. L. A. Bidwell, Dean.

North-East London Post-Graduate College.—This post-graduate school is established in connection with the Tottenham Hospital, N., which is recognised by the University of London as a place of post-graduate study for the M.D. and M.S. degrees. Facilities are here afforded to qualified medical practitioners for taking part in the work of an active general hospital, and for attending demonstrations of various branches of medicine, surgery and gynæcology, with opportunities for clinical instruction in diseases of the eye, ear, throat, nose, skin, in fevers, psychological medicine, the administration of anæsthetics, and dentistry. Cliniques, lectures and demonstrations are given by members of the teaching staff in the lecture room, in the wards, in the various out-patient departments, and in certain affiliated institutions. Operations are performed every afternoon of the week, except Saturday. Special classes, the attendance at which will be limited, are arranged in gynæcology, the surgical diseases of children, including orthopædic surgery, diseases of the throat, nose and ear, diagnosis of diseases of the nervous system, ophthalmoscopy and refraction, analysis of the gastric contents, clinical examination of the blood, diseases of the skin, abdominal surgery, radiography, bacteriology, and medical electricity. The fee for a three months' course of study, which may be begun at any time, in any single department, is one guinea. A fee of three guineas admits to the whole practice of the hospital for a similar term (one month, 2 guineas), and a perpetual ticket for the practice of the hospital may, for the present, be obtained on payment of a fee of 5 guineas. Additional information with a syllabus of lectures demonstrations, and special classes, may be obtained from the Dean of the Post-Graduate College, Dr. A. J. Whiting, 142, Harley Street, W.

PROVINCIAL MEDICAL SCHOOLS.

Bristol University College.—Faculty of Medicine.—The lectures and instruction given in the

Faculty of Arts and Science of University College, Bristol, are adapted to the various preliminary examinations, and students can complete in Bristol the entire course of study required for the medical and surgical degrees of the University of London and the Royal College of Surgeons of England, and of the Apothecaries' Society of London, and for the examination of the Army and Navy Boards. Students of the college are admitted to the clinical practice of those very important and well-equipped institutions, the Bristol Royal Infirmary and the Bristol General Hospital. The infirmary and the hospital comprise between them a total of 470 beds, and both have very extensive out-patient departments, and special departments for the diseases of women and children, and of the eye, ear, and throat, besides large outdoor maternity departments and dental departments. Students of the college also have the privilege of attending the practice of the Bristol Royal Hospital for Sick Children and Women, containing 104 beds, and that of the Bristol Eye Hospital, with 40 beds. The total number of beds available for clinical instruction is therefore 614. Very exceptional facilities are thus offered to students for obtaining a wide and thorough acquaintance with all branches of medical and surgical work.

Appointments.—At the Royal Infirmary, and also at the General Hospital, clinical clerks and dressers reside in the house in weekly rotation. A pathological clerk is appointed every three months. Also obstetric clerks and ophthalmic dressers. Clinical lectures are given regularly at both institutions.

Scholarships, Prizes, &c.—Prizes and certificates of honour are given in University College in all the subjects of the curriculum. There are two entrance scholarships, value £50 and £30 respectively, two Martyrs memorial scholarships (pathology and morbid anatomy) of £10 each, the Tibbits memorial prize, value £9, for proficiency in practical surgery, Henry Marshal prize, £12; Clarke Scholarship, £15; Sanders Scholarship, £22 10s.; one gold and silver medal awarded by the committee, and various prizes for clinical work in surgery and medicine.

Fees.—School fees for attendance on all courses of lectures, except comparative anatomy, 70 guineas, or 55 guineas. Dental composition fee, 60 guineas. Clinical fees—Surgical practice, one year, 12 guineas; perpetual, 20 guineas. Medical practice, 20 guineas; perpetual medicine and surgery, 35 guineas; clerk or dresser, 5 guineas; obstetric clerk, 3 guineas.

Prospectus and further information on application to the Dean, Professor E. Markham Skerritt.

Sheffield University College.—*Faculty of Medicine.*—The Winter Session, 1905-6 will commence in the new University building on Monday, October 2nd.

The University was opened on July 12th by the King. The plan of the buildings is that of four blocks, enclosing a quadrangle, 154 ft. by 110 ft. The medical department occupies the entire north wing overlooking the quadrangle on one side and Weston Park on the other. The anatomical department occupies about two-thirds of the upper ground floor. The dissecting room has been designed and equipped to meet all modern requirements of the student of anatomy. The lecture theatre will accommodate fifty students, and is provided with a lantern of modern type illuminated by the electric arc. The anatomical museum has a gallery which is set apart chiefly for anthropological and morphological collections. The floor space affords accommodation for bones, models, and spirit specimens mounted in glass jars. Research laboratories and private rooms are provided for the professors and demonstrators. The department of physiology occupies the first floor. In the general laboratory, a large and well lit room, accommodation is provided for microscopical work at a bench running the full length of the laboratory beneath the windows; the space behind is occupied by movable tables each equipped for the purposes of experimental work, an arrangement which enables the students to work either singly or in small groups. The fixed equipment of the room is designed to provide power for machinery, gas, electricity, and water wherever the tables may be situated. The second laboratory for chemical physiology is fitted with benches, fume cupboards, &c. In addition a considerable portion of the space in this room is devoted to and equipped for work of a more advanced type. Opening into this laboratory are a balance room and two rooms fitted for photography, spectroscopy, &c. Opportunities are afforded for research work in three special rooms. One, beautifully lighted by windows in two of its walls, is equipped for general research, another a room which can be darkened for optical work and photographic recording; and a third in the basement is provided with the solid pillars, &c., necessary for work with delicate instruments requiring great stability. In the lecture theatre, seating fifty students, a large amount of space has been left for the demonstration of experiments, and is equipped with the larger pieces of apparatus necessary for such work. The whole upper storey of the medical block is occupied by the Department of Pathology. The students' laboratory, a very large and lofty room, is fitted and equipped with every modern appliance for microscopical and bacteriological work. The lecture theatre has sitting accommodation for about fifty students. The incubating room, built into the centre of the pathological department, is a special feature; it is so arranged that it may be kept at a constant temperature, thus replacing the ordinary incubating ovens. The museum is spacious and is furnished with a gallery. Research laboratories are provided for the professor. On the upper ground floor are well-furnished lecture rooms for other subjects, and the materia medica museum. The library of the Sheffield Medico-Chirurgical Society, to which students are admitted, is situated on the ground floor overlooking the quadrangle.

Hospital practice is taken out at the Royal Infirmary (247 beds) and at the Royal Hospital (160 beds), both of which institutions have special departments for diseases of the eye, ear, and throat, and skin. At the latter there is also an extensive dental department. Perpetual fee, £45; or in two payments, viz., £26 on entrance, £22 within twelve months afterwards. Students are also admitted to the practice of the Jessop Hospital for diseases of women (80 beds), the City Fever Hospitals, and the South Yorkshire Asylum. The dental department is recognised by the examining bodies. The courses of instruction for the D.P.H. are recognised by the University of Cambridge, London University, and the Royal College of Surgeons.

Students of either sex are admitted to the degrees of the University.

The Kaye scholarship, for second year's students, natives of Sheffield, is awarded annually, under certain regulations. Prizes for clinical medicine and clinical surgery; prizes in books and certificates awarded annually.

University of Wales, Cardiff School of Medicine.—This college, which is one of the colleges of the University of Wales, has since its foundation, in 1883, prepared students for the Preliminary Scientific examination of the University of London, and for the corresponding examinations of other licensing bodies. In 1893 Chairs of Anatomy and Physiology and a Lectureship in Materia Medica and Pharmacy were established, making it possible for students of medicine to spend three out of the five years of prescribed study at Cardiff. Arrangements with the managing committee of the Cardiff Infirmary give students of the College the privilege of attending this large and well-ordered hospital, which is situated within five minutes' walk of University College. Many students, especially from Wales and Monmouthshire, avail themselves of the opportunities thus afforded to pursue the earlier part of the medical curriculum near home. All classes are open alike to both men and women students over sixteen years of age. The courses of instruction given at Cardiff are recognised as qualifying for the examinations of the Universities, Royal colleges, and other licensing bodies of Great Britain and Ireland. Having spent two or three years in study at Cardiff, and having passed the examinations in these years, a student may proceed to London or elsewhere and complete his qualifying course for a University degree or for a college diploma.

Students preparing for the first and second examinations of the Conjoint Board for England, or for the corresponding examinations of the Conjoint Board for Scotland, or for those of the Society of Apothecaries, may compound for their classes by paying a single composition fee of £41 10s., or by paying £20 and £24 10s. at the beginning of their first and second years respectively. Those preparing for the preliminary scientific and intermediate examination in medicine of the University of London may compound for their three years' instruction at Cardiff by paying a single composition fee of £57 10s., or by paying £13 13s., £28, and £21 at the beginning of their first, second and third years respectively.

In 1899 a department of Public Health was established, and lecturers in bacteriology and in public health and hygiene were appointed. Medical men preparing for a diploma in Public Health and Hygiene can attend complete courses of lectures and laboratory instruction in this department. These courses are recognised by the University of Cambridge, by the Royal Colleges of Physicians and Surgeons, and by Victoria University.

In the case of medical students, attendance on the class of hygiene and public health is accepted by the Universities of London and Cambridge, and by the Conjoint Examining Board of England

Courses of lectures to midwives, adapted to the requirements of the Central Midwives' Board, under the Midwives Act, are commenced in October, January, and April. The lectures are suitable both for pupil midwives and practising midwives, as well as for nurses who desire to enter for the examination for certification under the Act.

Scholarships, &c.—The attention of students about to matriculate is drawn to the numerous entrance scholarships for exhibitions which are offered at the college for competition in September, most of which may be held by medical students. Full particulars of the examination for these may be obtained from the Registrar, or from the Dean of the Medical Faculty.

Liverpool Royal Southern Hospital.—The clinical school of this hospital is situated within convenient distance of the Liverpool University, and affords every facility for clinical and pathological study. The hospital contains 200 beds, and in addition to the general medical and surgical cases attention is devoted to the diseases of women and children. There is a special ward for tropical diseases in connection with the University laboratories.

The medical and surgical staff visit the wards daily, and the ward instruction is supplemented by weekly clinical lectures. Additions have been made to the teaching staff so that students may now obtain instruction in diseases of the eye, ear and throat. Demonstrations in the use of the X-ray apparatus are given at intervals. There is an excellent pathological department, with laboratory attached, where demonstrations are arranged for and regular instruction is given in practical pathology. The practice of St. George's Hospital for Diseases of the Skin is free to students, and thus ample opportunity is afforded for acquiring a knowledge of dermatology. In addition to the clinical clerkships which are allotted to the students the resident posts of ambulance officers are given to the students whom the board may think most suited to hold them every three months. The Alexander Fellowship in Pathology of £100 a year is open to students of this school; three prizes of £5 each are also awarded to the gentlemen who present the best taken series of medical and surgical cases. *Fees:* Perpetual, £26 5s.; one year, £10 10s.; six months, £7 7s.; three months, £4 4s.

There are rooms for a limited number of resident students: terms (exclusive of fee for hospital practice), £15 15s. per quarter. The practice of the hospital is recognised by all examining bodies.

Leeds University.—This school of medicine was originally founded more than seventy years ago as the Leeds Medical School. The building, erected on a site contiguous to the infirmary, and opened eleven years since, contains one of the finest dissecting rooms in the Kingdom, extensive laboratories for physiology and pathology with the most recent improvements in fittings and apparatus, ample lecture-room accommodation, a large library, and separate museums for pathology and anatomy. Professors and lecturers are attached, and the clinical teaching is given by the physicians and surgeons attached to the Leeds General Infirmary, one of the largest in the United Kingdom, having 432 beds, with a staff of physicians and surgeons of considerable eminence. Ophthalmic demonstrations and demonstrations of skin diseases are given in the infirmary by surgeons in each department, where also are obtainable various clinical clerkships, dresserships, and other appointments; and an extern maternity charity is attached, at which the necessary attendance at labours can be taken. Besides the infirmary there is a large dispensary, a large hospital for infectious diseases, and a hospital for women and children, all of which are open to students of the school.

Scholarships, Prizes, &c.—(1) A Gilchrist scholarship of £50 a year for three years is awarded annually. (2) A University scholarship of £25 (awarded annually). (3) An entrance scholarship of 64 guineas. There is also a Hardwick prize in clinical medicine, a M'Gill prize in clinical surgery, each of the value of £10, and Thorpe prizes of £10 and £5 in forensic medicine and hygiene, and a Scattergood prize in midwifery, besides silver and gold medals and other class prizes. The composition fee for attendance upon all the required courses of school lectures is 64 guineas for University students who have attended the preliminary scientific courses, and the same for non-University students, exclusive of chemistry and biology.

At the General Infirmary, the perpetual fee for medical and surgical practice and clinical lectures is £42 in one sum, or two instalments of £22 each. These fees are not included in the composition fees for lectures and are payable separately.

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A scholarship of £42 to cover the cost of medical and surgical practice is offered annually by the Infirmary.

Liverpool School of Tropical Medicine.—This school, which has for its object research into Tropical Diseases and Improvement in Tropical Sanitation, was founded in Liverpool in 1899 by Sir Alfred Jones, K.C.M.G., who is the chairman of the school. The research work of the school is carried on at the Johnston Laboratories, in Liverpool University. The clinical work is carried on at the Royal Southern Hospital. A special feature of the work of the Liverpool School of Tropical Medicine has been the despatch of a large number of important medical expeditions to various places in the tropics, especially West Africa. Although the School has only been in existence for a short time it has already sent over a dozen of these expeditions. In addition, the School has issued a number of valuable publications and monographs on subjects connected with tropical diseases. The Duke of Northumberland, K.G., is Hon. Vice-President; Sir Alfred L. Jones, K.C.M.G., Chairman of Council; and Mr. Wm. Adamson, Vice-Chairman; and the following is the school staff: Sir Alfred Jones Professor, Ronald Ross, C.B., F.R.S., F.R.C.S.; Walter Myers Lecturer, J. W. W. Stephens, M.B.Cantab; Lecturer in Economic Entomology and Parasitology, R. Newstead, F.S.A. Lecturer in Tropical Diseases of Animals, H. E. Annett, M.D.; Walter Myers Fellow, J. Everett Dutton, M.B., Ch.B.; Assistant Lecturer, C. Christy, M.D.; Demonstrators and Research Assistants, J. L. Todd, B.A., M.D., C.M. McGill, and H. Wolferston Thomas, M.D., C.M. McGill; Dean, Professor Rubert

Boyce, M.B., F.R.S.; Hon. Secretary, A. H. Milne, B.A.

The following are the principal provincial hospitals having the greatest number of beds, to which students are admitted where clinical instruction can be obtained, but to which there is no medical school attached :—

BATH ROYAL UNITED HOSPITAL.—This is a well-appointed hospital in the West of England, with 130 beds, at which students can obtain clinical instruction. The hospital is recognised by the Colleges, and is licensed for dissection. It contains also an excellent museum and library. Fee for six months' attendance, five guineas; twelve months', ten guineas.

BRADFORD INFIRMARY.—The hospital contains 220 beds. Non-resident pupils are received and abundance of clinical material is obtainable. One year's attendance is recognised by the Examining Boards. Fee, perpetual, £10 10s.

BRIGHTON SUSSEX COUNTY HOSPITAL contains 190 beds. It is recognised by the College of Surgeons and by the Conjoint Board. Out-pupils are admitted to the clinical teaching and the classes at a fee of £21 for two years.

LIVERPOOL NORTHERN HOSPITAL, which has recently been rebuilt, now contains 246 beds, and is completely equipped with the most modern appliances. Clinical instruction is given by the staff during the summer and winter sessions. Clinical clerkships and dresserships are open to all students without additional fees. Fees for hospital attendance: Perpetual, £26 5s.; one year, £10 10s.; six months, £6 6s.; three months, £4 4s.; practical pharmacy, £2 2s.

NORFOLK AND NORWICH HOSPITAL.—This hospital is recognised by the Colleges, and contains 220 beds. Fees, £10 10s. for six months, £15 15s. for twelve months' medical and surgical practice. Pupils, resident and non-resident, are admitted.

NORTHAMPTON GENERAL INFIRMARY.—The number of beds is 163. Out-pupils are received, and have every opportunity of acquiring a practical knowledge of their profession. Instruction is also given in anatomy and materia medica and practical pharmacy. Non-resident pupils are taken at a fee of £10 10s.

ROYAL BERKSHIRE HOSPITAL.—The town of Reading, in which this hospital is situated, has a very large working-class population, and excellent opportunities for clinical instruction in the wards and extensive out-patient department are afforded here. It contains 160 beds, a splendid library, in which the Reading Pathological Society holds its mettings.

THE ROYAL HOSPITAL, Portsmouth.—The hospital is a preparatory school of medicine and surgery, and the attendance of pupils is recognised by the Examining Boards. The number of beds is 120. The fees are the same as at all similar institutions,

ROYAL DEVON AND EXETER HOSPITAL, Exeter.—The hospital contains 200 beds (including special children's wards), and has a good library, museum, dissecting room, and post-mortem room. Attendance on the practice of this hospital qualifies for all the Examining Boards. Arrangements can be made by which students can attend midwifery on application to the House Surgeon.

NORTHAMPTON GENERAL HOSPITAL.—This hospital contains 174 beds; it has been recently enlarged and re-arranged. Non-resident pupils are received and have every opportunity of acquiring a practical knowledge of their profession. The fee is £10 10s.

WOLVERHAMPTON GENERAL HOSPITAL.—The hospital contains 230 beds, attendance at this hospital being recognised by all the Examining Boards. Pupils are trained in clinical work by the medical and surgical staff. *Fees:* Six months, £6 6s.; twelve months, £12 12s.; perpetual, £21.

Ireland.

THE IRISH MEDICAL SYSTEM.

THE system of medical teaching in Ireland differs from that in England in important particulars. In London each clinical hospital has its attached medical school, which is fully equipped, and which educates the students of that hospital and very seldom those of any other. In Dublin, on the contrary, the hospitals and schools are entirely separate (except that Sir Patrick Dun's Hospital is officially connected with Trinity College), and a student of any hospital is free to enter for the whole or any part of his course at any school or hospital he pleases. As might be expected, religion. social rank, and locality of residence have their influence in causing certain classes of students to resort to schools and hospitals suitable to their condition. But scholastic or collegiate regulations impose no restrictions as to the place of study, and as the school and hospital fees are paid in detail in Dublin, and not in a lump sum, as in London, the pupil is free to do as he pleases.

BOARD AND RESIDENCE.

There is in Dublin no organisation for domestic accommodation of medical students, save for those who are passing through Trinity College, in whose case rooms and "commons" (*i.e.*, dinner) are provided at fixed rates. Those who can afford to pay £6 6s. or £7 7s. per month for their lodging and maintenance may find accommodation in the family of some medical man who receives boarders, in which case they become members of the family for the time being. The majority of Dublin students, however, take a lodging in some economical locality, or they "chum" with some other student for the purpose. It is usual to contract with the lodging-house keeper for board or partial board, but some students cater for themselves.

COST OF MEDICAL EDUCATION IN IRELAND.

The cost of obtaining a medical qualification depends to some extent on the qualification sought. In this connection the following tables may be of use to the prospective student :—

COST OF MEDICAL EDUCATION.

School of Physic, Dub. Univ. ..	£122 6s. 6d.
Royal College of Surgeons School	£124 19s.
Catholic University School ..	£124 19s.
Queen's College	About £110

COST OF DIPLOMAS OR DEGREES.

Dublin University	£27 (to this must be added £83 4s., the cost of obtaining an Arts degree).
Royal University	£15.
Conjoint Royal Colleges ..	£42.
Apothecaries' Hall	£22 1s.

Thus, the absolute payment will amount to somewhere between £125 and £232 10s. 6d. according as the teaching of the Queen's Colleges and the degrees of the Royal University, or the teaching and degrees of Dublin University, are taken. For the Conjoint Colleges the entire cost is £166 19s., taking the minimum mode of payment. So that, assuming that extras or voluntary costs are incurred the total will vary, say, from £170 to £200. "Grinding" although not officially recognised, occupies a position almost identical with that of the extra-mural instruction in other schools. Its cost must be reckoned among the expenses of the course, for, while not essential, it has become customary for almost all students to obtain aid in their studies in this way. As a rule, this private instruction costs about £5 5s. for each of the four examinations.

The above sum, or something like it, may be expended by the student or his parent in paying for lectures, &c., and examination fees as they fall due, and there is no difficulty in obtaining the needful information for his guidance if he likes to pay for his course in this fashion. If, on the other hand, he prefers to pay a large sum down, he can "apprentice" himself to a teacher who will undertake all monetary responsibility for his education. This so-called "apprenticeship," is very generally a simple contract for the payment of fees, and involves but little special teaching. The practice has now become almost obsolete. All the Dublin schools require fees to be paid in advance.

DATE OF ENTRY.

The entry of names and commencement of study in Ireland is *supposed* to date from the 1st of October in each year, but the session really dates from the 1st of November, and the entry of names may be delayed by the dilatory to the 25th of the same month. It should, however, be remembered that no credit is given for studies or attendance until the entry is regularly made. The student must attend three-fourths of the lectures delivered, and if he loses a fortnight at the beginning he must make up for it afterwards by constant attendance.

The student begins work by attending a recognised medical school each morning at ten o'clock, and occupying his day, to five p.m., between lectures and dissections. His vacations are a fortnight at Christmas and a week at Easter, and he finally returns home at the end of June.

PRELIMINARY EXAMINATIONS.

The first act of the student is to pass a preliminary examination, without which he cannot get credit for any medical studies pursued. The next is to commence medical study. This he does by entering for lectures at a medical school. From the school registrar he gets a form of certificate, and his third act is to take it or send it to the Branch Medical Council, 35 Dawson Street, Dublin, unless, as is usually the case, this duty is undertaken for him by the school registrar. He is thereupon placed upon the Register of Medical Students (without fee), and his period of study counts from that date. He must register at the earliest possible moment, or he may lose credit for his work.

The only preliminary examination held specially for medical students is that held conjointly by the Royal Colleges of Physicians and Surgeons, but other examinations, *e.g.*, the public entrance at Trinity College, the matriculation of the Royal University, the Intermediate Examination passes in the required subjects, and all other examinations recognised by the General Medical Council are accepted as equivalent.

The subjects of examination as prescribed by the General Medical Council are as follows:—1. English language, including a specified author, dictation, grammar, and composition; also parsing and analysis from a book specified. 2. Latin, including grammar, translation from specified authors, and translation of easy passages not taken from such authors. 3. Elements of mathematics, comprising (*a*) arithmetic, including vulgar and decimal fractions; (*b*) algebra, including simple equations; (*c*) geometry, Euclid, Books I., II., and III., with easy deductions. 4. One of the following optional subjects:—(*a*) Greek, (*b*) French, (*c*) German.

THE IRISH LICENSING BODIES.

The Medical Licensing Bodies of Ireland are four in number, and, as a rule, students gravitate into one or other of five classes:—*a.* Those who enter Trinity College, and take a full graduation in Arts in addition to their professional degrees. *b.* Those who take the licence of the conjoint Royal Colleges of Physicians and Surgeons. *c.* Those who take their qualifications at the Royal University of Ireland, where graduation in Arts is not necessary. *d.* Those who take the licence of the Apothecaries' Hall. *e.* Those who pursue their studies in Ireland, but who migrate to London, Edinburgh, or Glasgow for their licences. Almost all these last-named emigrants come from the Queen's Colleges, and the greater number of them from Belfast, while the Dublin students qualify, as a rule, in Dublin.

We do not attempt to give details as to the requisite courses of instruction for degrees or diplomata, as our epitome must necessarily be insufficient for the information of the student, and we can occupy our available space with information more useful to him. The official information upon which students may depend can be obtained by sending a note to the Registrars of the Licensing Bodies or Schools.

The Irish Licensing Bodies are as follows:—

THE UNIVERSITY OF DUBLIN.

The University of Dublin grants the degrees of M.B., B.Ch., and B.A.O. to students who have obtained their Arts degree, and who have been for at least five academic years on the books of the Medical School, and the higher degrees of M.D., M.Ch., and M.A.O. to those who have held, or have been qualified to hold, for at least three years, the grade of M.B. and B.Ch. It does not grant degrees to any but full graduates in Arts, consequently its degrees hold the highest rank of social and educational qualifications, and are sought for by those who look forward to occupying the best positions in the profession.

The expense of obtaining the degrees of M.B., B.Ch., and B.A.O. is approximately as follows:—Lectures, £66 13s. 6d.; Hospitals, £55 13s.; Degree Fees, £27.—Total, £149 6s. 6d.

The expense of the B.A. degree, amounting altogether to £83 4s., should be added, making the total cost £232 10s. 6d.

Important new regulations come into force in the Summer Session of 1906. One of the main results of these will be to diminish the extent of the Arts course for medical students, while at the same time preserving the advantage of an Arts education by rendering the attendance on certain lectures compulsory. Changes in the medical examinations will also take place, but the curriculum itself is practically unaltered.

In addition to its ordinary qualifications the University grants the following higher degrees:—

Doctor of Medicine.—To obtain this the candidate must have obtained the degree of M.B., or have been qualified to have obtained it for three years. He must then read a thesis before the Regius Professor of Medicine. Fee for this degree, £13.

Master of Surgery.—The candidate must be a Bachelor in Surgery of three years' standing, and must then pass an examination in clinical surgery, operative surgery, surgical pathology, surgery, and surgical anatomy (on the dead subject). Fee for this degree, £11.

Master in Obstetric Science.—The candidate must have passed the M.B. and B.Ch. examinations, and have completed, in addition to the courses for M.B., B.Ch., a course of obstetric medicine and surgery. He is then required to pass an examination in the following subjects:—Practice of midwifery, gynæcology, anatomy of female pelvis and elementary embryology, and clinical gynæcology. Fee for this degree, £5.

Diplomate in Medicine, Surgery, and Midwifery — Candidates for the diplomas in Medicine, Surgery, or Obstetric Science must be matriculated in Medicine, and must have completed two years in Arts and five years in medical studies. The course and examination is the same as for the degrees, except that the lectures and examinations in botany and zoology need not have been taken out or passed, and that the candidate need not have obtained an Arts degree. Fee for the diplomas in medicine, surgery, and midwifery, £21. A diplomate, on completing his course in Arts and proceeding to the degree of B.A., may become a Bachelor by attending the lectures on botany and zoology, passing the previous medical examination in those subjects, and paying the degree fees.

Diploma in Public Health.—The candidate must be an M.D. or a Graduate in Medicine and Surgery of Dublin, Oxford, or Cambridge, must have completed, subsequent to registration, six months' practical instruction in a laboratory, and also have studied practically outdoor sanitary work for six months under an approved Officer of Health (*v.* also page 276).

Degree and Licence in Dental Science.—Candidates for the degree in dental science must have taken a degree in Arts, and must have had their names in the books of the Medical School for five years. Two examinations must be passed—namely, the Previous Dental at the end of the second year, and the Final Dental at the end of the fifth year. Candidates for the Licence are required to matriculate in Arts, but need not proceed further in the Arts course. The course of study is the same as for the degree with the exception that no lectures in pathology or bacteriology are required. The total fees for the licence, including the premium for Dental Mechanics (£100), are £200 17s., while those for the degree are about £210, to which must be added the cost of the B.A. degree.

Post-Graduate Classes.—A short post-graduate course is now given annually in July in connection with Trinity College Medical School. It includes special work on Diseases of the Eye, Nose, and Throat, Gynæcology, Diseases of the Skin, X-ray work, Medicine, Surgery (clinical and operative), and Clinical Pathology.

Royal Services School.—The object of this school is to prepare candidates for the Indian Medical Service, and Royal Army Medical Service. It is conducted on a comprehensive scale, and affords special opportunities for operating on the cadaver, and for the study of commentaries. Two sessions are held yearly, each lasting for about ten weeks.

THE ROYAL UNIVERSITY OF IRELAND.

The Royal University of Ireland is purely an examining body. Its degrees are granted on one year's acts, *i.e.*, the matriculation examination of this University (none other will suffice) and a "first University examination" at the termination of the first year. The cost of the M.B. and M.Ch. of the University, with all the necessary curriculum, is about £125. Some of the Arts examinations are conducted, not only in Dublin, but at certain local centres.

The University confers the following medical degrees:—

M.B., B.Ch., B.A.O., and the higher degrees of M.D., M.Ch., and M.A.O. It also confers a Diploma in Public health and a Diploma in Mental Diseases.

All degrees are open to persons of either sex.

The University examinations are held in the spring, beginning about May 1st, and in the autumn, beginning about October 1st.

All candidates for any degree must pass the matriculation examination and the first University examination.

The course for the degree of M.B., B.Ch., B.A.O., extends over five years.

Students will be admitted to the first University examination after one year from matriculation. Fee, £1.

The medical course consists of three previous examinations, one at the end of each year, and one degree examination at the end of the fifth year. Fee for each previous examination, £1; for the degree examination, £2; for the diploma, £10.

In addition, the following degrees are granted:—

Diploma in Public Health.—Conferred only on graduates in medicine of the University of at least twelve months' standing. Fee, £2. Subjects.—Meteorology, bacteriology, chemistry, physics, vital statistics, hygiene, sanitary engineering, architecture and law.

The M.D. Degree.—Conferred only on graduates in medicine of the University of three years' standing. They must at the same time produce a certificate of having been, for at least two academical years, engaged in hospital or private, medical, surgical, or obstetrical practice, or in the military or naval medical service. The examination comprises medical diseases and the theory and practice of medicine, including pathology. Every candidate will be examined at the bedside, and be required to diagnose at least three medical cases, and prescribe treatment, and to write detailed reports on at least two cases to be selected by the examiners and to discuss the questions arising therefrom. Fee, £5.

The M.Ch. Degree.—Conferred only on graduates in medicine of the University of three years' standing, and who can produce a similar certificate of practice to that required for the M.D. degree. The examination comprises surgery, both theoretical and operative; surgical anatomy; ophthalmology and otology. Fee, £5.

The M. A. O. Degree.—Conferred only on graduates in medicine of the University of three years' standing, and who can produce a similar certificate of practice to that required for the M.D. and M.Ch. degrees. The examination comprises midwifery and diseases of women and children. Fee, £5.

Prizes, &c.—First Examination in Medicine. Two first-class exhibitions of £20 each, and two second of £10 each.

Second Examination in Medicine.—Two first-class exhibitions of £25, and two second-class of £15, and the Dr Henry Hutchinson Stewart Medical Scholarships, value £10 a year for three years. The latter are awarded in psychological medicine, diseases of the nervous system, and anatomy, physiology and pathology of brain, cord, and nerves. Competition among medical graduates of not more than three years' standing. Fee £2. Value £50 a year for three years.

Third Examination in Medicine.—Two first-class exhibitions of £30 each, and two second of £20 each.

Medical Degrees Examination.—Two first-class exhibitions of £40 each, and two second of £25 each. One travelling medical scholarship of £100. One medical studentship of £200 per annum, tenable for two years.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

These examinations are held conjointly by the two Colleges. The course, as in other bodies, extends over five years, with examinations at the end of the first, second, third, and final years. These examinations are conducted by examiners chosen by each of the Colleges for the subjects appropriate to them. The curriculum has recently been revised, and made of a more practical nature. In common with the English Colleges, the subjects of the First Professional examination may be studied either at a medical school or at an institution other than a medical school recognised by the Colleges, after due inspection, for instruction in these subjects. We recommend students to apply for the official programme to the Secretary of the Committee of Management, Royal College of Physicians, or to the Registrar of either College. In the case of the Preliminary Examination seven clear days' notice must be given to the Secretary; fourteen days' notice is required from candidates for the Professional examination.

The total of the examination fees, spread over the four examinations, is £42, while the school and hospital fees, if taken in Dublin, amount to £124 19s., making altogether £166 19s., exclusive of re-examination fees, which have to be paid in case the candidate fails to pass his examination.

The Conjoint Colleges also confer a diploma in Public Health, of which information will be found on page 276.

ROYAL COLLEGE OF PHYSICIANS.

This College issues a Licence in Medicine and a Licence in Midwifery to Registered Medical Practitioners.

The subjects of examination for the former qualification are:—Practice of Medicine, Clinical Medicine, Pathology, Medical Jurisprudence, Midwifery, Hygiene and Therapeutics.

The candidate for the Licence in Midwifery must produce certificates of having attended a course of lectures on Midwifery, and of having attended practical Midwifery and Diseases of Women for six months, at a lying-in Hospital or Maternity recognised by the College; or, where such Hospital attendance cannot have been obtained during any period of the candidate's course of study, of having been engaged in practical Midwifery under the supervision of a Registered Practitioner holding a public Medical appointment, the certificate in either case to state that at least twenty labour cases have been actually attended. A Registered Medical Practitioner of five years' standing is exempted from the examination by printed questions.

Fees.—Fee for the Licence to Practise Medicine,

£15 15s. Fee for the Licence to Practise Midwifery, £3 3s.

Membership.—The Examinations for Membership are held in January, April, July, and October.

ROYAL COLLEGE OF SURGEONS.

This College grants a licence in Surgery to registered medical practitioners. Candidates who hold registrable surgical diplomas, including the licence of the Apothecaries' Society of London, granted since October, 1886, are admitted to examination without further evidence of study, but candidates who hold medical qualifications only, including the L.S.A. granted before October, 1886, will be required to produce certificates of two courses of lectures in anatomy and dissections, one course of practical histology, one course of lectures in surgery, and one course of operative surgery.

Candidates are examined in surgery, clinical and operative; surgical appliances; and ophthalmic surgery. The fee is £26 5s. The fee for a special examination is £31 10s.

A diploma in Midwifery is also granted after examination to registered medical practitioners. Candidates must produce evidence of (*a*) attendance on a course of lectures on midwifery and diseases of women and children in a recognised school; (*b*) attendance or six months' practice at a recognised lying-in hospital or recognised dispensary for lying-in women and children; and (*c*) of having conducted at least thirty labour cases. The fee for the examination is £15 15s.

Fellowship.—Candidates for the Fellowship of the College must enter their names with the Registrar at least a month before the date of examination, in order that the Council may decide whether to approve of the application. Examinations are held the third Mondays in February, May, and November. If the application is approved, the candidate will be admitted to the next sessional examination or to a special examination (except during the months of August and September) if granted by the Council. Candidates are divided into two grades:—

Grade 1.—Licentiates or graduates in surgery of less than ten years' standing.

Grade 2.—Licentiates or graduates in surgery of more than ten years' standing.

Candidates in Grade 1 must pass two examinations—Primary (in anatomy and physiology) and Final (in surgery). Candidates in Grade 2 need pass but one examination in surgery, surgical anatomy, and surgical pathology.

Fees.—Grade 1.—For Licentiates of College; Primary examination, £15 15s.; Final examination, £10 10s. Licentiates in Surgery of other licensing bodies: Primary examination, £26 5s.; Final examination, £15 15s. Students of the College: Primary examination, £5 5s.; Final examination, £21. Students of other licensing bodies: Primary examination, £10 10s.; Final examination, £31 10s.

Grade 2.—Licentiates of the College, £26 5s.; Licentiates in Surgery of other licensing bodies, £42.

APOTHECARIES' HALL OF IRELAND.

The Licence of this Hall is granted to students who present certificates of having fully completed the course of study as laid down in the curriculum. The diploma of the Apothecaries' Hall of Ireland entitles the holder to be registered as a practitioner in medicine, surgery, and midwifery, and he also possesses the privileges of an apothecary.

There are four professional examinations, the total fees for which amount to 21 guineas. Women are eligible for the diploma.

Candidates already on the "Register" will receive the diploma of the Hall upon passing an examination in the subjects which are not covered by their previous qualification, and on paying a fee of ten guineas; if medicine or surgery is required, two guineas extra will be charged.

The fees payable for each examination are as follows: First Professional, £5 5s.; Second, £5 5s.; Third, £5 5s.; Final Examination, £6 6s.

A candidate is allowed for each professional examination which he has completed at any other licensing body, except the Final. If he has passed only in some of the subjects in a given examination, he has to pay the whole of the fee for that examination.

The fees for re-examination are: For each subject, £1 1s., excepting in the subjects of chemistry, pharmacy, surgery, medicine, second anatomy, and ophthalmology, the fees for which are £2 2s. each.

The fee for the Third and Final, or Final alone, is £15 15s., when the other examinations have been taken elsewhere.

All examination fees are to be lodged in the Sackville Street Branch of the Royal Bank of Ireland to the credit of the Examination Committee.

Applications and schedules, together with bank receipt for the fee, must be lodged with the Registrar, Apothecaries' Hall, 40, Mary Street, Dublin, at least fourteen clear days before the day of examination.

Candidates who desire to obtain the Letters Testimonial of the Apothecaries' Hall of Ireland, must, before proceeding to the Final Examination, produce evidence of having been registered as medical students for fifty-seven months; also of having attended courses of instruction as follows:

One course each (winter course of six months) of the following: Anatomy (lecture), chemistry (theoretical), midwifery, practice of medicine, physiology or institutes of medicine and surgery. Dissections, two courses of six months each.

Courses of three months.—Materia medica, medical jurisprudence, chemistry (practical), practical physiology and histology, operative surgery, physics, clinical ophthalmology, biology, clinical instruction in mental disease, pathology, vaccination.

Medico-Chirurgical Hospital, twenty-seven months to be distributed over the last four years of his study. The candidate may substitute for nine months in this, hospital attendance for six months as a resident pupil.

Three months' study of fever.

Six months' practical midwifery and diseases of women.

Three months' practical pharmacy in a recognised clinical hospital or a recognized school of pharmacy, or a year in the compounding department of a licentiate apothecary or a pharmaceutical chemist.

Each candidate before receiving his diploma must produce evidence that he has attained the age of 21.

Each candidate must produce evidence of having before entering on medical studies passed a preliminary examination in general education recognised by the General Medical Council, and of having been registered by that Council as a student in medicine. Certificates of medical study will not be recognised if the commencement of the course to which the certificate refers dates more than fifteen days prior to such registration, except in the subjects of physics and biology. This registration is not undertaken by the Hall.

The details of the course of education required and syllabus of the examinations will be supplied on application to the Registrar, at 40, Mary Street, Dublin.

LICENCE IN DENTAL SURGERY.

There is probably no specialty in surgery which gives as great a number of its practitioners a living and the prospect of an income as dentistry. A young man who has got his diploma and knows something of his business, and is willing to attend to it, seldom fails to get a substantial foothold in Ireland in a few years. The University of Dublin grants both a Degree and a Licence in dental surgery. To obtain the former, candidates must have taken a degree in arts; the licence is obtainable by all duly qualified persons who have passed the Public Entrance Examination of Trinity College, Dublin. The Royal College of Surgeons in Ireland grants a Licence in Dentistry.

Course of Study for the Licence in Dentistry.—Candidates are required to pass three examinations, *viz.*:—Preliminary (in General Education), Primary Dental, and Final Dental.

All information concerning this licence may be obtained from the Registrar of the College. The Primary Dental Examinations commence on the second Monday in the months of February, May, and November. The subjects of examinations include physics, chemistry (including metallurgy), anatomy, physiology and histology, and surgery. The fees for the primary Dental Examination amount to £10 10s; and for re-examination, if rejected, £5 5s. The Final Dental Examinations commence on the Thursdays immediately following the Primary Dental Examinations. Candidates are examined in dental surgery, theoretical (including dental pathology), clinical, and operative; and in dental mechanics, theoretical, clinical, and practical (including the metallurgy of the workshop). Candidates must pass in all the subjects at the same time.

The fees for the Final Dental Examination in the case of candidates holding the L.R.C.S.I., or students who have passed the Primary Dental or Third Professional Examination of the College, £10 10s.; re-examination, £5 5s. The fees for Final Examination of all other candidates, £26 5s., and for re-examination, £10 10s. The extra fee for Special Examination, £5 5s. A rejected candidate will not be again admitted to examination until after a period of three months.

THE DIPLOMA IN PUBLIC HEALTH.

THIS diploma is granted by Dublin University, the Royal University, and the conjoint Royal Colleges. Every candidate must be a registered medical practitioner. The examination is in :—(1) Chemistry (including chemical physics). (2) Engineering and architecture. (3) Sanitary law and vital statistics. (4) Hygiene. (5) Bacteriology. (6) Meteorology. The General Medical Council recommend that all candidates shall have studied in a special bacteriological laboratory, also for six months as pupil of a working medical officer of health, described, for Ireland, as " the medical officer of health of a county or of one or more sanitary districts having a population of not less than 30,000; or a medical officer of health who is a teacher in Public Health of a recognised medical school."

In addition to taking the prescribed course a candidate for the D.P.H. of the University of Dublin must be a Doctor in Medicine or a graduate in Medicine, Surgery, and Midwifery of Dublin, Oxford, or Cambridge, and his name must have been on the " Medical Register " for at least twelve months before the examination. The Royal University only confers its diploma on its own graduates.

THE DIPLOMA IN PSYCHOLOGICAL MEDICINE.

The Royal University of Ireland grants a diploma for proficiency in the treatment of mental diseases under the following conditions :—

The diploma is conferred only on graduates in medicine of the University. Candidates must give notice, in writing, to the secretaries of their intention to present themselves, and must pay the prescribed fee of £2 at least one month previous to the examination. Candidates who satisfy the examiners will be required to pay a further fee of £3 before the diploma is conferred. The subjects for this examination are those required by the Hutchinson Stewart Scholarship for proficiency in the treatment of mental diseases.

THE IRISH MEDICAL SCHOOLS.

The Irish Medical Schools are as follows :—

THE SCHOOL OF PHYSIC OF DUBLIN UNIVERSITY.—This school is formed by an amalgamation of the School of Trinity College and of the College of Physicians.

Every student of the school must be matriculated by the Senior Lecturer, for which a fee of 5s. is payable, but he need not attend any of the Arts course unless he desires to obtain a University licence or degree in medicine, surgery, and midwifery. No student is permitted to matriculate unless he has passed the entrance examinations of the University, of the Royal University, of the College of Surgeons, or some other examination recognised by the General Medical Council.

Two medical scholarships are given annually at the School of Physic, value £20 per annum, tenable for two years, the examinations for which are held each year in June; one scholarship is given in anatomy and institutes of medicine; the other in zoology, chemistry, botany, and experimental physics.

A prize of £100 is awarded by the Board to the successful candidate at a special examination in alternate years in medicine or in surgery, provided that the merit be deemed sufficient. The successful candidate is required to spend three months in the study of medicine or surgery, as the case may be, in Berlin, Paris, or Vienna. Before he can obtain the first instalment of £50 he must satisfy the Senior Lecturer that he possesses sufficient knowledge of a Continental language to derive full benefit from the prize. The examination is held in June, and is open to students who have passed the Final Examination in Medicine or in Surgery, as the case may be, within two years of the examination.

In order to obtain the second sum of £50 the prizeman must have furnished to the Regius Professor his formal report on the hospitals attended by him within two years from the time of obtaining the prize.

Class prizes are given at the end of the session of between £5 and £10 in value.

The John Mallet Purser Medal, founded by Prof. Purser's past pupils, is awarded annually to the student who, at the ordinary June " Half M.B." Examination in Anatomy and Institutes of Medicine, shall obtain highest marks in Physiology and Histology, provided that he passes the examination in full.

Fitz-Patrick Scholarship.—This scholarship consists of the interest on £1,000. It will be awarded annually to the student who obtains the highest aggregate marks at the five sections of the Final Examinations, provided that he has completed his medical course in the prescribed period of five years.

THE ROYAL COLLEGE OF SURGEONS IN IRELAND. SCHOOLS OF SURGERY.—These schools are attached by Charter to the Royal College of Surgeons, and have existed as a department of the College for over a century. They are carried on within the College buildings, and are specially subject to the supervision and control of the Council, who are empowered to appoint and remove the professors, and to regulate the methods of teaching pursued. The buildings have been reconstructed, the capacity of the dissecting room nearly trebled, and special pathological, bacteriological, public health, chemical, and pharmaceutical laboratories fitted with the most approved appliances, in order that students may have the advantage of the most modern methods of instruction. A refreshment room is now open, where students can have luncheon. There are special rooms set apart for lady students. The entire building is heated by hot-water pipes, and lighted throughout by the electric light.

All the lectures and courses of practical instruction may be attended by medical students who are otherwise unconnected with the College.

The diplomas of the College are open to students of either sex. Separate rooms have been provided, and careful provision made for the instruction and comfort of women students.

Prizes.—The Barker Prize, £31 10s.; the Carmichael Scholarship, £15; the Mayne Scholarship, £8. The Gold and Silver Medals in Surgery and the Stoney Memorial Gold Medal in Anatomy.

Class Prizes of £2 and £1, accompanied by medals if sufficient merit is shown, will also be given in each subject. Prospectus and Student's Guide can be obtained on written application to the Registrar, Royal College of Surgeons, Dublin.

THE CATHOLIC UNIVERSITY SCHOOL is situated in Cecilia Street, Dame Street. It prepares students for all medical examinations, particularly those of the Irish Colleges of Physicians and Surgeons, and the Royal University of Ireland. The school has recently been rebuilt and refitted, its working space having thereby been nearly doubled, and several new laboratories, including those for the study of bacteriology and public health, have been added. The institution has also been recently chartered, under the Educational Endowment (Ireland) Act, and it is now controlled by a Board of Governors. The total fees for school and hospital courses is £160, payable as the courses are taken out.

The following Exhibitions are awarded annually:—Two first year's, value £12 10s. each; two second year's, value £10 each; one third year's Royal Exhibition of £12 10s.; one final Conjoint Colleges Exhibition of £12 10s.; two large gold medals, besides several other class medals.

A Guide for Medical Students, which gives all the information required by parents, and by students who desire to join the medical profession, may be obtained free on application to the Registrar.

THE QUEEN'S COLLEGES—BELFAST, CORK, AND GALWAY.

These three important academic institutions were the special schools of the Queen's University. They have ceased to have any direct relation to a central examining body, but educate students for all colleges and degrees, and are maintained, as hitherto, by a handsome Government grant. The same curriculum as that formerly adopted is continued, and the various exhibitions and scholarships are still available. Each college has the disposal of about £1,500 per annum in scholarships and prizes. The curriculum is generally well adapted for preparation for the Royal University examination. The colleges are well adapted for high-class technical education, having lecture rooms provided with every appliance necessary in the modern training of a medical student. The colleges are completely equipped with students' reading rooms and lending libraries and refreshment rooms, and with all adjuncts to collegiate life, such as literary societies and athletic organisations. The expense of living in the collegiate towns is quite moderate. The course of lectures in the winter session must be diligently attended, no student obtaining a certificate who has not put in three-fourths of a course. The scholarship examinations are held in October.

QUEEN'S COLLEGE, BELFAST.

The total cost of the medical curriculum of the Royal University of Ireland, including examination fees and perpetual fee for the Royal Hospital, but not including fees for the special hospitals, is about £95. If the Conjoint Examination of the Royal Colleges is taken the expense is almost the same.

Clinical instruction is given at the Royal Victoria Hospital. The Union Hospital, the Maternity Hospital, the Ulster Hospital for Women and Children, the Hospital for Sick Children, the Ophthalmic Hospital, the Ulster Eye, Ear, and Throat Hospital, and the District Lunatic Asylum are also open to students.

Prizes.—(1) Ten medical scholarships each year, value £20 each; (2) two Dunville studentships (one each alternate year), value £150 each; (3) one Andrews studentship each alternate year, value £140; (4) numerous sessional prizes.

During the summer session special classes are formed in bacteriology and clinical pathology, and during the winter facilities are afforded to medical men to work at these subjects in the pathological laboratories. From time to time lectures and demonstrations are given in the anatomical department on the Advanced Anatomy of the Nervous System, or some other department of applied anatomy.

A pamphlet containing full information can be had on application to the Registrar, Queen's College, Belfast.

QUEEN'S COLLEGE, CORK.

The arrangements in the Faculty of Medicine are made chiefly with reference to the requirements of the Royal University of Ireland, but students proceeding for the examinations of the Conjoint Boards of England, Scotland, or Ireland, the Society of Apothecaries of London, or the Apothecaries Hall of Ireland, can arrange the course of lectures which they attend, and the order in which they attend them, to meet the requirements of those bodies. Certificates of attendance in the college are also accepted by the University of Cambridge. The total fees for the college lectures and Hospital attendances required by the Royal University of Ireland is about £85.

Clinical instruction is given at the North and South Infirmaries. Students can also attend the Mercy Hospital, the Cork Union Hospital, the County and City of Cork Lying-in Hospital, the Maternity, the Hospital for Diseases of Women and Children, the Fever Hospital, the Ophthalmic and Aural Hospital, and the Eglinton Lunatic Asylum. The winter session commences on October 27th, and ends at the end of April. The courses of the summer session are delivered in the months of April, May, and June.

Scholarships and Prizes.—Eight medical scholarships, two in each of the first four years, of the value of £25 each, and in the fifth year the Blaney Scholarship of the value of about £32, and a Senior Exhibition, value £30. Three Exhibitions, one in practical medicine, one in practical surgery, and one in practical midwifery, each of the value of £15. Book prizes at the sessional examinations.

Further information can be obtained in the College Regulations, or on application to the Registrar, Queen's College, Cork.

QUEEN'S COLLEGE, GALWAY.

Clinical teaching is carried on in the Galway Hospital, established as a Public General Hospital (in the place of the County Galway Infirmary) by Act of Parliament (1892). The Galway Fever Hospital is also open to students. The medical lectures are recognised by the Royal University of Ireland and the various Licensing Bodies in the United Kingdom.

Prizes.—There are eight Junior Scholarships in Medicine of the annual value of £25 each. Two are tenable by matriculated students of the first, second, third, and fourth years. The Council has power to award exhibitions for distinguished answering. Sessional prizes are offered in each subject. A Senior Scholarship in Anatomy, value £40, the holder of which is usually appointed Demonstrator, is offered annually for competition, tenable for one year by a student who shall have attended the Medical School of the College for at least two sessions, and shall have obtained a Degree in Arts or Medicine, or a Diploma in Medicine, from a Licensing Body. Scholarship examinations are held at the commencement, and those for Sessional Prizes at the close, of each session.

THE PHARMACEUTICAL SOCIETY OF IRELAND.

The Pharmaceutical Society of Ireland issue two qualifications and a certificate. The qualification of Registered Druggist; the qualification of Pharmaceutical Chemist; and the certificate of competency as Assistant to a Pharmaceutical Chemist.

Registered Druggist.—This qualification entitles the holder to keep open shop for the selling, retailing, and mixing of poisons. In order to obtain it, a person must now have served an apprenticeship or assistantship of four years to an apothecary, pharmaceutical chemist, or to a person who was, or would have been entitled to become, a registered chemist and druggist or a registered druggist, and be 21 years of age. He shall be examined with respect to his knowledge of English orthography and composition, arithmetic, and the weights and measures of the British Pharmacopœia, the appearance and properties of the various drugs and chemicals in general use, and as to the provisions of the Poisons Act. The fee is four guineas.

Examinations in Dublin (also in Belfast and Cork or other place if 12 candidates offer) on the second Tuesday of January, April, July, and October.

Pharmaceutical Chemist.—The qualification of a pharmaceutical chemist in Ireland confers greater privileges than is the case in England.

The subjects of examination are divided between the "Preliminary" and the "Licence."

The Preliminary examination is held on the first

Thursday and following day of January, April, July, and October.

The fee is £2 2s. for the first attempt, and 10s. 6d. for each subsequent examination. Further particulars with reference to the subjects for examination may be obtained from the Registrar. The British Society's examination is accepted in lieu of this, as well as those recognised by the General Medical Council as a preliminary to medical studies.

Pharmaceutical Licence Examination.—This examination confers the title of Pharmaceutical Chemist and the right to compound medical prescriptions. Candidates must be 21 years of age, and must have passed the Preliminary at least a year previously. They must, unless having passed the Preliminary previous to 1884, produce certificates of having served four years as assistant or apprentice to an apothecary or pharmaceutical chemist or four years to a druggist, two years to an apothecary or pharmaceutical chemist, also a certificate of having attended a course of practical chemistry of not less than three months' duration, and of having actually worked at the bench for 100 hours during the said course at a recognised school; and also a course of botany and materia medica. The fee for examination is five guineas, and for re-examination a guinea and a half. Examinations are held in Dublin on the second Wednesday and following day of January, April, July, and October.

Assistant to a Pharmaceutical Chemist.—The examination for the certificate of competency as an assistant may be described, in brief, as the same as that for the Licence, minus the examination in chemistry and botany, with the fee reduced to one guinea (half a guinea on the second and subsequent attempts). The Preliminary examination must be passed as for the Licence, and the usual 14 days' notice must be given. Candidates must have been engaged in practical pharmacy for four years.

Examinations are held on the second Mondays of February, May, August, and November, or on such days as the Council may direct.

DEPARTMENT OF AGRICULTURE AND TECHNICAL INSTRUCTION FOR IRELAND.

Royal College of Science for Ireland.

Session 1905—1906.

This College, situate in St. Stephen's Green, Dublin, supplies a complete course of instruction in science applicable to the industrial arts, especially those which may be cast broadly under the heads of agriculture, chemical manufactures, engineering, physics, and natural science. A diploma of Associate of the College is granted at the end of the three years' course. Non-associate students may join for any course required. There are several entrance scholarships, (*a*) in agriculture, and (*b*) in science and technology, tenable for three years, of the value of £50 each yearly, with free tuition. There are four Royal scholarships of the value of £50 each yearly, with free education, tenable for two years. Two are competed for by the first year associate students at the end of each session. All the laboratories and drawing schools are open daily for practical instruction. The Session commences on Tuesday, October 3rd.

The courses of chemistry, physics, botany, geology, and mineralogy and zoology are recognised by the Royal University of Ireland, and certificates of attendance are granted to medical and other students attending these courses, as also the courses of the chemical, physical, zoological, botanical, and geological laboratories.

The Entrance and Science Scholarship Examinations are held about the first week in July, and the Examinations for Agricultural Scholarships in the second week in September.

THE DUBLIN HOSPITALS.

The clinical hospitals in Dublin are ten in number, exclusive of three lying-in hospitals. There are also two children's hospitals, an orthopædic hospital, a fever hospital, an ophthalmic hospital with two centres, a dental hospital, and other special institutions. Some of the clinical hospitals, though they have no actual or official connection with any school, are in close affinity with certain teaching bodies; while others, again, are without any special connection with any school. While, however, such affiliation of a school or hospital may exist, it should be remembered that the Dublin schools and hospitals are open to all comers, and the student is competent to attend any hospital or any school he wishes, and to change his place of instruction from year to year as he may see fit.

The Irish Licensing Bodies require attendance on hospitals for twenty-seven months, *i.e.*, three winter sessions of six months and three summers of three months, with the five years of study. The fee at all general hospitals is £8 8s. in winter, and for the summer £6 6s., or £12 12s. for the entire session of nine months if taken together.

GENERAL HOSPITALS.

Richmond, Whitworth, and Hardwicke Hospitals.—The accommodation at these hospitals is as follows:—Hardwicke Hospital, 120 beds; Whitworth Hospital, 82 beds; Richmond Hospital, 110 beds—total, 312 beds. These hospitals are visited each morning at nine o'clock by the physicians and surgeons, and in addition to the usual bedside instruction, clinical lectures are delivered on the most important cases. Instruction is also given on various special branches of medicine and surgery. The Truss Establishment, for the distribution of trusses to the ruptured poor of Ireland, is connected with these hospitals. There are very large ophthalmic, aural, throat, and gynæcological dispensaries, and instruction in these important subjects is given. Eight resident clinical clerks are appointed each quarter, and provided with furnished apartments, fuel, &c. The appointments are open not only to advanced students, but also to those who are qualified in medicine and surgery. A house surgeon for the Richmond Hospital and a house physician for the Whitworth and Hardwicke Hospitals are elected every six months, and receive a salary. The Richmond Lunatic Asylum, containing 1,600 beds, adjoins these hospitals.

Meath Hospital and Co. Dublin Infirmary.—This hospital was founded in 1753, and now contains 160 beds available for clinical teaching. A new building for the isolated treatment of fevers, containing 40 beds, has recently been added. The certificates of this hospital are recognised by all the Universities and licensing bodies of the United Kingdom. Medical and surgical resident pupils and clinical clerks and dressers are appointed every three months, and a house surgeon is elected annually. A prospectus giving the complete arrangements for medical and surgical classes for the coming session may be obtained from the Secretary of the Medical Board, Mr. William Taylor, F.R.C.S., 32, Harcourt Street, Dublin.

The Adelaide Medical and Surgical Hospitals occupy a central position within a few minutes' walk of the College of Surgeons and Trinity College. From October 1st, the physicians and surgeons visit the wards and give instruction at the bedside at the advertised hours. There is a large detached fever hospital, and also wards for infants and children. Operations are performed, except in cases of urgency, at 10 a.m. on Tuesday, Thursday, and Saturday. Special hours are devoted to clinical instruction in the diseases peculiar to women, and students are individually instructed in the use of the stethoscope, ophthalmoscope, laryngoscope, and microscope; also special instruction is given on practical pathology and X-ray photography. A House Surgeon is elected annually and four resident pupils half-yearly. Prize examinations, including examinations for the Hudson Scholarship, £30 and a gold medal, and a senior prize of £10 and a silver medal, in addition to surgical and medical prizes, are held at the termination of the session. The large dispensaries afford facilities for the study of eye, ear, throat, and cutaneous diseases, as well as of minor surgery and dentistry. Further particulars from Mr. Heuston, F.R.C.S.I., 15, St. Stephen's Green North.

The Royal City of Dublin Hospital.—This hospital has recently been enlarged and improved to a very considerable extent. A special course of instruction is given on ophthalmic and aural disease. There are special wards for the treatment of diseases of the eye, of children, and of women, and practical instruction is given on diseases peculiar to women; there is also a separate building for infectious diseases. Clinical clerks to the physicians and dressers to the surgeons are appointed from the most deserving of the class. A new operation theatre, sterilising room, and anæsthetic room have been constructed in accordance with the most modern surgical requirements. A Röntgen-ray and light treatment of lupus department has recently been added. A resident medical officer is elected annually, and resident medical and surgical pupils are appointed from among the past and present students of the hospital. Operations are performed on Tuesdays, Thursdays, and Saturdays, at 10 a.m. Special classes for first year students. Full particulars can be had on application to Mr. G. Jameson Johnston, M.B., F.R.C.S.I., Hon. Sec. Med. Board.

Sir Patrick Dun's Hospital is situated on the south-eastern side of the city, and about half a mile from the University School of Physic. It is officered almost exclusively by the professors and examiners in that school. Formerly all University students were compelled to attend this hospital, which was purely a medical institution, but some years ago the obligation was removed, and the hospital was opened for surgical cases. It is now free to all students. There is a special wing devoted to fever cases, and regular clinical instruction is given by the members of the medical staff throughout the winter and summer sessions. Special classes for students commencing their hospital studies will be held in these departments during the months of October, November, and December. They will embrace the elements of medicine and surgery, including note-taking. Opportunities are also afforded to students for examining cases of throat, ear, and eye diseases, as well as for performing minor surgical operations and bandaging. In the X-ray Department opportunities are given the members of the hospital class of seeing the various applications of the X-rays to the diagnosis and treatment of injury and disease.

Mater Misericordiæ Hospital.—This hospital, containing 335 beds, is open at all hours for the reception of accidents and urgent cases. Fifty beds are specially reserved for the reception of patients suffering from fever and other contagious diseases. A course of lectures and instruction on fever will be given during the winter and summer sessions. A certificate of attendance upon this course to meet the requirements of the various licensing bodies may be obtained. Opportunities are afforded for the study of the diseases of women in the wards under the care of the obstetric physician, and at the dispensary, held on Tuesdays and Saturdays. Lectures on clinical gynæcology will be delivered on Saturdays at 11 a.m. Ophthalmic surgery will be taught in the special wards and dispensary. A special course of instruction in pathology and bacteriology, as applied to medicine, will be given. Connected with the hospital are extensive dispensaries, which afford valuable opportunities for the study of general, medical and surgical diseases, accidents, &c. Leonard Prizes: One gold and one silver medal will be offered for competition annually in the subject of medicine, and one gold and one silver medal in the subject of surgery. Junior Leonard Prizes: Two prizes of the value of £3 and two prizes of the value of £2 will be offered for competition in medicine and surgery respectively.

Mercer's Hospital.—This hospital, founded in 1707, is situated in the centre of Dublin, in the immediate vicinity of the Schools of Surgery of the Royal College of Surgeons, the Catholic University School of Medicine, and Trinity College. It contains 120 beds for medical and surgical cases, and arrangements have been made with the medical officers of Cork Street Fever Hospital whereby all students of this hospital are entitled to attend the clinical instruction of that institution and become eligible for the posts of resident pupil, &c. There is a large out-patient department, and a special department for diseases peculiar to women. There are also special wards for the treatment and study of children's diseases. During the past few years the hospital has undergone extensive alterations in order to bring it up to modern requirements. A house surgeon is appointed annually. Five resident pupils are appointed, each for six months, and clinical clerks and dressers are appointed monthly from among the most deserving members of the class. The certificates of this hospital are recognised by all the licensing bodies. For further particulars apply to Mr. R. Charles B. Maunsell, M.B., F.R.C.S., 32 Lower Baggot Street, Dublin.

St. Vincent's Hospital was established in 1834, it has 160 beds, and in connection with it there is a largely-attended dispensary, a convalescent home, and a nurses' institute. In addition to the ordinary clinical instruction, systematic courses of lectures are given in each department of medicine and surgery, and are illustrated by cases in the hospitals. The resident officers consist of a house surgeon, a house physician, and four resident pupils. Three clinical lectures are delivered daily in the wards, illustrated by selected cases, and beginning at 9 a.m. Two gold medals and other valuable prizes and certificates of merit are awarded at the end of each session. A prospectus can be had from Surgeon Fagan, 31, North Frederick Street.

Dr. Steevens' Hospital, situated at Kingsbridge, is one of the oldest and largest of the clinical hospitals in Dublin, and contains over 200 beds. Recently, a very fine Nurses' Home has been added to the institution, with accommodation for over seventy nurses. And a new and thoroughly equipped dispensary and out-patient department has been completed and opened to patients. There is accommodation for twelve resident pupils—four medical, six surgical, and two in the special departments, each of whom is supplied with a separate room. All information with regard to these appointments can be had from the Resident Medical Officer at the hospital. Licensing bodies recognise six months' residence as equivalent to a year's ordinary attendance at hospital. The manufactories and railway works in the neighbourhood supply this hospital with large numbers of accidents and other cases, while the special ward for venereal diseases affords exceptional opportunities for the study of this important subject.

Jervis Street Hospital is the oldest established in Dublin. The new hospital was completed in 1896, since which time it has been open for the reception of patients. In addition to large medical and surgical dispensaries, the out-patient department includes special departments for the treatment of diseases of the skin, eye, ear, and throat, and diseases peculiar to women. Two resident surgeons are appointed annually. Clinical clerks and surgeons' dressers are selected from among the most attentive of the advanced students without the payment of any additional fee. Twelve interns are appointed annually, and are provided with apartments, &c., free of expense. Special certificates are given to resident pupils and dressers who have performed their respective duties to the satisfaction of the physicians and surgeons. Gold and silver medals are given after examinations held at the close of the summer session.

Students of Jervis Street Hospital are entitled to attend free of charge the Children's Hospital, Temple Street, which contains 100 beds, and where special lectures are given on Diseases of Infancy and Childhood, and on Orthopædic Surgery and appliances.

SPECIAL HOSPITALS.

The special hospitals of Dublin are the Rotunda, the Coombe, and the National Lying-in-Hospitals, Cork Street Fever Hospital, the Royal Victoria Eye and Ear Hospital (amalgamation of St. Mark's Ophthalmic Hospital and the National Eye and Ear Hospital), the

Dental Hospital, the Throat Hospital, the Orthopædic Hospital, the Children's Hospitals in Harcourt Street and in Temple Street, and the City Hospital for Diseases of the Skin.

The Rotunda Hospital.—This institution is the largest, the longest established, and the most famous gynæcological as well as maternity hospital in the British Empire. The work performed by it is about three times greater than that of any other hospital of its kind in Ireland. The number of patients admitted to the hospital, and also attended in the extern maternity has increased enormously within recent years. The routine daily work comprises the attendance of lectures on midwifery and gynæcology; practice in abdominal palpation; personal conduction of parturition both in the extern and the intern maternities; cystoscopic examinations, as well as attendance at the operation work of the hospital. The hospital affords exceptional advantages to qualified men who take out a three months' course during the autumn, winter, and spring months, for they (if considered competent) are permitted a certain amount of practical operation work, viz.—forceps, curettings, perineorrhaphy, &c. Students are liable to summary dismissal without refund of fees for gross misconduct, or serious breach of the hospital rules. A special afternoon class in gynæcology is held by the Senior Assistant, £2 2s. per month. The Pathological laboratory under the direction of Dr. Rowlette has become an important feature of the hospital. Students can enter at any time for periods of one month or longer. Certificates of attendance are accepted by all the licensing bodies. The L.M. certificate is obtained by attendance at the hospital for six months, with the subsequent passing of an examination. A special certificate in gynæcology is presented to students whose work meets with the Master's approval. Paid clinical assistants are selected (from among those who have obtained the hospital L.M. certificate) by competitive examination, for periods of six months. The residents' quarters have undergone complete renovation and now afford comfortable accommodation. The grounds of the hospital contain asphalt and grass courts for lawn tennis and croquet. There is also a full-size billiard table.

Fees for Pupils.—Intern:—One month, £6 6s.; two months, £9 9s.; three months, £12 12s.; six months, £21; single months other than the first, £4 4s; board and lodging in the house per week, £1 5s. Night students (not resident in house), £6 6s. for first three months; £4 4s. for the second three months. For further particulars apply to E. Hastings Tweedy, Master, Rotunda Hospital, Dublin.

Coombe Lying-in Hospital.—This hospital consists of two divisions, one of which is devoted to lying-in cases, and the other to the treatment of diseases peculiar to women. The practice of this hospital is one of the largest in Ireland; nearly 18,000 cases are treated annually, either as intern or extern patients. Lectures are delivered, practical instruction is given, and gynæcological operations are performed in the theatres daily. There is a general dispensary held daily, at which instruction is given on the diseases of women and children. There is a special afternoon dispensary held by the Master and his assistants, at which practical instruction in gynæcology is given. This is the largest dispensary of its kind in Dublin. There is no extra charge for attendance at this dispensary. There is accommodation for a number of qualified and unqualified intern pupils, who enjoy exceptional advantages of acquiring a thorough knowledge of this branch of their profession. Lady medical students can reside in the hospital. Clinical assistants are appointed from among the pupils as vacancies occur. Certificates of attendance at this hospital are accepted by all licensing bodies, and the diploma is recognised by the Local Government Board as a full legal midwifery qualification. The residents' quarters have been much enlarged. A billiard table has been erected for the use of students. Extern pupils pay, for full course of six months, £8 8s. Intern pupils pay one month, £4 4s.; six months, £18 18s. Board and lodging in the hospital, 18s. per week. Lady students' intern pay for one month, £5 5s.; each consecutive month, £4 4s.

* **National Maternity Hospital.**—This institution, under the mastership of Dr. Barry and Dr. A. Horne, is situated in Holles Street.

Sir Patrick Dun's Maternity.—This is a branch of Sir P. Dun's Hospital, and is under the management of the King's Professor of Midwifery in Dublin University. The department is at present in process of being reorganised.

Cork Street Fever Hospital is the only special fever hospital in Dublin. It is supported mainly by subscriptions, an annual Government grant, and capitation grants for patients. Regular clinical instruction is given during the winter and summer sessions to those who desire a special course in fevers. There are also courses for the Diploma in Public Health. All particulars may be obtained on application to the Medical Superintendent.

The National Children's Hospital for the treatment of all non-infectious diseases peculiar to children, with which the Pitt Street Children's Hospital, founded in 1821, was amalgamated, is capable of containing 50 beds for the reception of cases of deformity and all other forms of surgical disease. There is a large general dispensary for extern patients held daily from 10 to 11. Operations are performed on Saturday at 12 o'clock. Practitioners and students can attend on application to Sir Lambert H. Ormsby, F.R.C.S.I.

***The Children's Hospital, Dublin** (under the care of the Sisters of Charity).—This institution is one of the most progressive and up-to-date children's hospitals in the Kingdom, besides being the largest in Ireland. There are 100 beds available for patients; about 1,000 cases are admitted to the wards annually; and about 7,000 or 8,000 seen in the dispensary. During the last year a new operating theatre has been opened. It is fitted and furnished in the best possible fashion for present-day surgery. Special attention is given to orthopædic surgery, and the number of deformities from all parts of Ireland treated and cured in the hospital is rapidly increasing. A special masseuse has been appointed to the hospital to aid in this department. A convalescent home for the institution has recently been acquired at Raheny; twenty beds are available. While situated in the country, it is within very easy reach of the sea, and during the summer the children are brought daily to the sea-side.

The hospital is recognised for clinical instruction in the diseases of children by the R.U.I. and licensing bodies, which require a certificate of instruction in this important branch of medical education. A nursing home is in connection with the institution, and trained nurses are always available for private cases. Senior students or others requiring a post-graduate course at the hospital should apply for full particulars to H. C. Mooney, hon. sec., or to any member of the staff.

The Incorporated Orthopædic Hospital, Ireland.—This hospital was founded in 1876, and contains 80 beds. It is available for every class of deformity available for treatment. Particulars may be obtained from Captain Borthistle, Registrar, at the hospital, or from R. L. Swan, F.R.C.S.I., 32 Stephen's Green.

The Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin.—This hospital, which was opened in March, 1904, is an amalgamation of St. Mark's Ophthalmic Hospital and the National Eye and Ear Infirmary. The hospital contains 80 beds. Clinical instruction in diseases of the eye and ear, including the use of the ophthalmoscope and operations, is given daily from 10 till 1. Special classes for practical instruction in the use of ophthalmoscope, &c., and for the demonstration of cases, are formed from time to time.

The Incorporated Dental Hospital, Lincoln Place.—This handsome hospital, recently erected, is the only special Dental Hospital in Dublin. It is officered by a very strong staff of the leading dental surgeons of Dublin, and has a large *clientèle* and extensive practice among the Dublin poor. The fees are £15 15s. for the first year's study, and £12 12s. for second, and proportionately smaller fees for shorter periods.

The City Hospital for Diseases of the Skin and Cancer, Great Brunswick Street.—The first and only one of its kind in the city was the first in Ireland to instal the Finsen treatment. Senior students are admitted free to the practice of this hospital, which has a large daily out-patient attendance. Classes of instruction will be given at regular intervals during the winter and summer sessions in the use of the Finsen light, X-rays, high frequency currents and radium, with demonstrations on (1) the production and use of the Röntgen rays, (2) electric currents, direct and alternating, with description of resistances, rectifiers and transformers; (3) accumulators, their construction, use, and methods in charging; (4) vacuum tube, choice of tube for particular kinds of work. Fluorescent screen, and how to localise foreign bodies.

BELFAST HOSPITALS.

* Hospital for Sick Children, Queen Street.—This institution, erected by voluntary donations, and supported by voluntary contributions, was opened for the reception of patients on April 24th, 1879. The hospital consists of a medical ward with twenty-eight beds, and one of a similar size for surgical cases. It is strictly non-sectarian in its principles, and is open to all denominations. Children from birth to the age of 12 years, and not suffering from contagious disease, are admissible as in-patients. A very large extern is conducted in the out-patient department between the hours of 9 and 10 a.m., where children from birth to 14 years are attended to. The convalescent home, which is situated at Newtownbreda, contains thirteen cots, and its situation and equipment render it an admirable adjunct to the after-treatment of the cases admitted to the hospital. During the winter session systematic courses of lectures and demonstrations in the medical and surgical diseases of infancy and childhood are delivered in the wards on Wednesday and Friday of each week at 9 a.m.

* Mater Infirmorum Hospital.—Established 1883. 160 beds.

The Belfast Maternity Hospital (Incorporated.)—Established 1794. 25 beds.—The practice of the Maternity Hospital, the certificate of which is recognised by the Royal University, &c., &c., is open to students. The fee for the session is £2 2s. Resident nurses are also received for training for a period of six months, and a diploma given which is recognised by public bodies. Conditions for such on application to the Matron. During the year 1904, 295 patients were treated in the hospital, and 291 patients at their own homes. Besides this, 278 patients were dealt with in the extern gynæcological department. Clinical lectures and bedside demonstrations are given by members of the staff during both the winter and summer sessions. Students wishing to attend should apply to Dr. H. D. Osborne, 32 Lonsdale Terrace, Belfast, Hon. Secretary to Medical Staff, on or before November 1st and May 1st.

Note.—Hospital was rebuilt during the year, and hence numbers were reduced during removal to the splendidly equipped new hospital in Townsend Street. A Resident Surgeon elected periodically.

Ophthalmic Institution and Eye and Ear Hospital, Great Victoria Street, Belfast.—Established 1844. New hospital erected, 1867. New extern department and operation theatre added, 1902. This hospital is situated on the main road between Queen's College and the Royal Victoria Hospital. It contains about 30 beds for intern patients, and a large extern department. The latter is open on Monday, Wednesday and Friday at noon for eye cases, and on Monday and Thursday at noon for ear and throat cases. Special courses of instruction are given during the winter and summer sessions, but students can enter at any time, and can always obtain plenty of practice in ophthalmoscopic work. Full particulars may be had from Dr. Cecil Shaw, 18 College Square East, Belfast.

Royal Victoria Hospital.—Established 1791; incorporated by Royal Charter, 1875 and 1898. New hospital opened, September 17th, 1903. 300 beds; Convalescent hospital, 24 beds; Children's Hospital, 33 beds; Consumptive Hospital, 10 beds.

Ulster Eye, Ear, and Throat Hospital.—Established 1871. New hospital opened 1874. 30 beds.

Ulster Hospital for Children and Women, Mountpottinger, Belfast, is the only hospital in the large part of the city situated on the County Down side of the river. It is placed in a working class district, and has a great field for its charitable operations. There are in the hospital about twenty-two beds for children and eight for women. There is an extern department for children open every week-day, except Saturday, from 9 till 10, and for women at 11.30, and a special department for diseases of the eye, ear, and throat on Tuesdays and Fridays from 9 till 10. During the summer and winter sessions, clinical instruction is given to students daily, operations being chiefly performed on Wednesday and Saturday. There is a resident midwife for extern work, and every facility is afforded students for attending their cases in the district.

CORK HOSPITALS.

Victoria Hospital for Women and Children.—Established 1874. 70 beds. An immense amount of work is done in this hospital to relieve the poor of Cork, Kerry, and other counties. This year a fine new anæsthetic room has been added to the already perfect theatre, where a large number of successful operations are done every year. The hospital contains several very fine private rooms for paying patients.

* County and City of Cork Lying-in Hospital.—Established 1798. 17 beds.

* Eye, Ear, and Throat Hospital, Western Road.—Incorporated 1898. 35 beds.

* Fever Hospital and House of Recovery.—Established 1801. 110 beds.

* Maternity.—Established 1872.

* Mercy Hospital.—Established 1857. 80 beds.

* North Charitable Infirmary.—Established 1774. 110 beds.

Cork South Infirmary and County Hospital.—Founded 1773. The hospital contains 100 beds, available for clinical instruction, 40 medical and 60 surgical. There are also special wards devoted to the treatment of diseases peculiar to women and children, and a large medical and surgical extern department.

Clinical instruction is given daily during the session from 9.30 to 11.30, in both the medical and surgical wards, and clinical lectures are regularly delivered.

The operation and sterilising rooms are thoroughly up to date. The X-ray department is fully equipped with the newest apparatus necessary for such work. Students are regularly instructed in the methods of using the rays by practical demonstration on the cases requiring their use.

The hospital has been largely availed of by students of the Cork School of Medicine.

GALWAY HOSPITALS.

* County Hospital.—Established 1786. 60 beds.

*** No answer to our request for information received from these hospitals.**

IRISH PUBLIC SERVICES.

The Poor-law Medical Service.

Unattractive as this Service was prior to 1898, it has become still more so in consequence of the changes which have been brought about by the passing of the Local Government Act in that year. The abolition of Dispensary Committees, in whom was vested the immediate control and management of the dispensaries, including the appointment of the officers, and the transference of these duties to the Boards of Guardians, have placed the medical officers under serious disadvantages, which are well-nigh unendurable, and have created such an amount of irritation and annoyance that a very strong prejudice now exists against entering the Service at all. For several years the unsatisfactory nature of the Irish Poor-law Medical Service, as a career for young practitioners, has furnished a theme for the opening addresses at all the leading medical schools. In addition to the petty annoyances, the laborious and harassing duties, and the ever-increasing amount of clerical work which the new orders of the Local Government Board impose from time to time, the unfortunate medical officers are grievously underpaid, their salaries being totally out of proportion to the duties discharged, and in the majority of rural districts barely sufficent to cover the out-of-pocket expenses, such as are incurred in the keep of a horse and man, and other servants. The Local Government Board have recently laid it down, moreover, that the dispensary patients have the first call on the time of the medical officer, and that, even if he is engaged on an urgent private case, he must give it up and go off to attend on a scarlet-runner, as the dispensary visiting tickets are not inappropriately called. So strictly is he bound up to the discharge of his duties that unless incapacitated by sickness or other cause, or with the permission of the guardians expressly granted, he cannot leave his district for a single day, even if he makes provision for the performance of his duties in his absence by a brother practitioner. The Irish Medical Association, whose work it is to safeguard the interests and improve the condition of the Poor-law medical officer, considers it an imperative duty to point out to young practitioners the following facts: (1) That the Poor-law Medical Service is one in which there is no promotion. (2) That it is a service where few facilities exist for original research, and still less for further medical culture, especially in the rural districts. (3) That, while medical education has become wider in its requirements, and more costly and difficult to procure, almost the same rate of payment given to less educated men forty years ago is still offered, and this, too, at a time when the rural prosperity of the country is less, and consequently lucrative private practice more difficult to obtain. (4) That there is no compulsory superannuation, and, as a consequence, many old and infirm doctors are forced to remain on in the Service long after they have become unfit to discharge the duties, seeing nothing but extreme poverty and perhaps the workhouse itself staring them in the face.

We need go no further than to say that the Irish Poor-law Medical Service is a service to avoid. To all who contemplate entering it we emphatically say, Don't. So important is it that young medical men should recognise what life in the Poor-law Medical Service means at present that we quote a short extract from a letter written by a member of it:—"We have no pay practically; no holidays. We are always on duty. We have no pension. We have no promotion. Consequently, every day spent in such a service is one day worse, which, I think, makes it fairly rank as the very worst service of any kind in the world, for any other service leads a man to promotion or pension. In addition, the fact of a man being in this service lowers his social status. Everything points to it being a service to be shunned."

Reforms must come eventually, but they will only come, as they have come in other services, in consequence of the dearth of candidates. The Irish Medical Association has found it necessary to adopt the following resolution:—"That henceforth no medical man shall apply for or accept any dispensary appointment at a smaller remuneration than £200 per annum, or workhouse appointment under £120 per annum, unless both be held conjointly, when the minimum salary shall be £300 per annum." Already the effect of this is being felt, and the difficulty of securing suitable candidates for vacant dispensaries has coerced the Local Government Board into trying to influence the Boards of Guardians into adopting for each union a graduated scale of salaries with triennial or quinquennial increments. Only a few Boards have adopted scales, and with one or two exceptions even the maximum salaries attainable under them, and which can only be reached after 25 or 30 years' service, fall far short of what the Irish Medical Association has laid down as an adequate remuneration. We therefore strongly urge on young medical men the importance of supporting the interests of the profession as a whole on this important question, and of not seeking appointments to which they may find perhaps in a few years, they are inextricably tied, and which they cannot relinquish, however much they may desire to do so.

There are 159 workhouses and about 810 dispensary medical officers, besides apothecaries. The number of vacancies that occur annually averages 100. The salary in this service used to average about £114, but is rapidly coming down, and when it is taken into consideration that in the vast majority of rural districts it is necessary to keep one or more horses, the average area being from forty to sixty square miles, it is plain that there will not be a large margin left from the public emoluments.

The medical officer is also *ipso facto* the registrar of births, marriages, and deaths, and medical officer of health for the district, under the Public Health Act, passed in 1873 and amended in 1878. The former office, in country districts, yields between £5 and £10 a year, and the emoluments of the latter appointment in very few cases reach £20, averaging about £12. The medical officer is also vaccinator for the locality, and is required to vaccinate everyone who wishes to come. For each patient a fee of 2s. is paid, along with his salary, by the guardians, and the sum total of those fees varies, according to the populousness of the district, from £4 to £100, an average for the provinces being about £10.

Qualifications.—The qualifications required by the Local Government Board are a licence in surgery, in medicine, and in midwifery; but registration in the "Medical Register," if effected since the passing of the Medical Act, in 1886, fulfils all requirements. The candidate must also be 23 years of age.

The appointment to both workhouse and dispensary lies with the guardians, who elect by vote. As politics and religious feeling run high in Ireland, these elements enter largely into the election of Poor-law medical officers. Family interests also possess great weight. In some districts an attempt has been made to insist upon the candidate being a member of the United Irish League. We need not—we trust—point out to any member of the medical profession that to endeavour to obtain a post on such a qualification as that of the membership of any political organisation is to commit an act which is unworthy of his profession.

Duties.—The duty of the dispensary doctor is twofold. He has to attend his dispensary on a given day or days in the week. Frequently there are two dispensaries in the district, separated from each other by several miles, and he will have, perhaps, to attend two days a week. He has also to visit at any hour of the day or night a sick person for whose relief a visiting ticket has been issued by a guardian, warden, or the relieving officer, and to continue his attendance as often as may be necessary to the termination of the case. Moreover, he has a great many registry books to keep and a multitude of returns to make, and in many districts he has to make up all the medicines for the poor.

The pressure of these duties is in a great degree dependent on the goodwill of the guardians. If the medical man is a favourite with his masters they will give him very little trouble with "scarlet runners," and will be unwilling to trouble him even with cases deserving of personal attendance. If, on the other hand, it is his misfortune to differ from the guardians, his position may become impossible. He may be peremptorily summoned in any weather, at any hour, and to any distance, to a case which he may probably find to be altogether trivial, or to a person whom he may know to be perfectly able to pay a fee.

Workhouse Hospitals.—The number of unions in Ireland is 159, to each of which is attached a medical officer, who is appointed and controlled by the board of guardians in the same manner as the dispensary medical officer. The salary is usually better than that of the dispensary doctor, and the duties of a more easy and satisfactory description, inasmuch as they are confined to daily attendance at the workhouse hospitals, and no night visits out of doors or long journeys across the country are involved.

The Irish Lunacy Service.

This service, at present, affords a comfortable livelihood for 22 Resident Medical Superintendents and 32 Assistants. The Superintendents receive salaries and allowances ranging, according to the number of inmates of the asylum, from £500 to £1,000 a year, and the Assistants receive salaries and emoluments averaging about £200 a year. There are also Visiting Physicians receiving about £120 a year, but this class of officer is being allowed to die out, and no new appointments will be made. The Superintendents and Assistants must devote their whole time to their duties.

Heretofore the appointments of Medical Superintendents have been in the patronage of the Lord Lieutenant, but, under the Local Government Act, they are in the hands of the County Councils, with the proviso that no one shall be appointed who is not a fully registered practitioner with five years' service as Assistant. The Assistant is appointed by the Committee of the County Council to which the management of the the asylum is entrusted. In addition to these officers, there are, in certain larger asylums, Clinical Residents, who receive about £50 a year and full allowances. These appointments afford excellent introduction to the higher places in the service.

Other Appointments.

There are, in addition to those which we have mentioned, centain appointments open to medical practitioners in special localities. They are :—

(1) Attendance on the Royal Irish Constabulary. (2) Attendance on the Coastguards. (3) Factory Surgeoncies. (4) Attendance upon the depôt soldiers who are not otherwise provided for.

The Constabulary are paid for at the rate of 2s. per month for each member of the force on duty in the district, including the wives and children of the men, but not of the officers. This includes the supply of medicines. The appointment to this position rests with the Inspector-General of the Royal Irish Constabulary, who usually acts upon the advice of the local District Inspectors as to the convenience of the men, and, of course, the emoluments depend on the number of Constabulary stations and the number of men in each.

The Coastguard Service.—The duty of the Medical Officer is to attend the men when sick and to examine candidates either for admission or for superannuation. The fees vary from 5s. to 2s. 6d. per visit. The appointments rest with the Admiralty, but are usually secured for the local Poor-law Medical Officer. The emoluments depend on the number of stations and men.

Factory surgeoncies are in the gift of the Chief Inspector of Factories in Whitehall. There is a set scale of payment by the factory owner to the inspector for this work, but we believe it is not adhered to, and, in some districts, at all events, the emolument is a matter of arrangement. The amount depends upon the size of the factory, the position being, in Dublin or Belfast, or in other large manufacturing centres, a lucrative one, but in other places scarcely worth taking. The attendance on the military depôts is not worth mentioning.

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Scotland.

Notwithstanding the increased competition which the recent vigorous growth of the great English provincial medical schools, added to the unsurpassed attractions of the historic Metropolitan hospitals, with their staffs of renowned teachers, ensures, the Scottish medical schools seem fully to retain their popularity, not only, as is natural, among Scotsmen and their colonial descendants, but among medical students from England, Wales, and Ireland, and, indeed, all parts of our Empire. In fact, if appearances be any guide, it would seem that the number of Oriental students attending classes in Edinburgh is increasing year by year. And undoubtedly the competition of other centres has had the advantage of making Scottish teachers bestir themselves, with the result that the efficiency of the medical schools is now much greater than a decade ago. The Carnegie bequest, which practically ensures free university education to all Scotsmen who are willing to take advantage of it, has not greatly increased the number of undergraduates, and it is thought that the increase from this cause has now attained its maximum. The benefits of the second half of the bequest, *i.e.*, the improved equipment of the teaching schools and the encouragement of post-graduate research are now manifesting themselves, and will prove permanent factors in promoting the well-being of the Universities and Scottish education generally. Of the four universities, Edinburgh, of course, occupies the premier position as a medical school, but at Glasgow, Aberdeen, and St. Andrews, an almost equally good—indeed, in individual details, better—training can be obtained. Two ordinary qualifications to practise are granted in Scotland—the M.B., Ch.B. of the Universities, and the triple qualification of the Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow. The examinations for the University degree naturally are more exacting than those for the triple qualification, and the curriculum wider. Nevertheless, the standard for the latter is being steadily raised, though on account of the large number of examiners in most subjects it is probably slightly less uniform than that of the universities, where the examinations are conducted by the professors with one or more extra-mural assessors in each subject. Two features of the Scottish system deserve mention—first, as regards the co-ordination of various separate teaching bodies in each centre ; second, as regards the conditions under which the students live, Around each university there has grown up an extra-mural medical school, in which the teachers are hospital physicians, surgeons, and specialists unconnected with the university, but whose classes qualify for graduation. Thus the student has usually ample choice, and can, within certain limits, attend the teacher from whom he thinks he will derive most benefit, while the extra-mural lecturers, being unendowed and constantly recruited by fresh blood, have a permanent incentive to keep their courses up to the mark, since any slackness is at once followed by a diminution in the number of students' fees. In hospital work it is the same, the student having the option of attending a clinical professor and an ordinary physician or surgeon. A very important part of the student's clinical work, too, is done at institutions and under teachers quite unconnected with the universities ; this is his dispensary practice, which may be taken at one of several dispensaries situated in the poorer districts of the towns. Until recently, practical training in obstetrics was one of the least satisfactory parts of the teaching in Edinburgh, and many students were in the habit of going to Glasgow or Dublin for their maternity work. Recently, however, steps have been taken which should render this unnecessary, and ought to give Edinburgh students quite sufficient opportunity of acquiring as good a practical acquaintance with this most important subject as they have of obtaining a theoretical knowledge of it. From what has been said it will be seen that university undergraduates and triple qualification men rub shoulders at every turn—in the wards, dispensary, and lecture-room. University students have the privilege of studying under both intra- and extra-mural teachers, while men going up for the triple qualification are limited to the latter. It is not uncommon, therefore, for a man to come up intending to take the licence, and to change his mind and go in for a degree, or *vice versâ*, and this can usually be done without much added expense or taking out many fresh classes, provided the change is not made too late in the curriculum The weak spot in the Edinburgh curriculum is the overcrowding of subjects in certain years. The most feasible means of remedying this would seem to be a division of the *annus medicus* into three instead of two sessions, a scheme which has received a certain amount of support, but is as yet far from becoming *un fait accompli*.

For the rest, the student lives as he likes and where he likes; the authorities only demand that he shall attend classes with due regularity and diligence, and exhibit sufficient proficiency to pass his examinations. Most men live in lodgings, a few board with private families, and some live in the various halls of residence which have been established. In these last, too, the student is his own master, the halls being managed solely by a committee of the residents for the time being. It is impossible to make any very definite statement as to the relative cost of a medical education in the different schools, as compared with London and Dublin, as so much depends on the extra classes taken out, the mode of living, and so on. The minimum inclusive fees for the licence are £120, for the M.B. degree about £145; but almost every student finds it practically necessary to attend additional classes. On the whole, the cost of living is highest in Edinburgh, lowest in Aberdeen; in the former, while the rent of lodgings is lower than in London, maintenance, including clothing and provisions, is somewhat more expensive. Incidental expenses, amusements, &c., are, however, considerably less in the Northern capital. In Aberdeen, money goes much further than in the south, and the student ought to keep himself on about two-thirds of the funds required in Edinburgh.

THE CARNEGIE TRUST.

Through the munificence of Mr. Andrew Carnegie, LL.D., payment is now made "of the whole or part of the ordinary class fees exigible by the Universities from students of Scottish birth or extraction, and of sixteen years of age or upwards, or scholars who have given two years' attendance, after the age of fourteen years, at State-aided schools in Scotland, or at such other schools and institutions in Scotland as are under the inspection of the Scottish Education Department."

The Trust provides for the payment of the class fees of the above students proceeding to graduation in medicine or science. Application for payment of class fees under the conditions of the Trust should be made to the Secretary, Mr. W. S. McCormick, Merchants' Hall, Hanover Street, Edinburgh.

Scholarships, Fellowships, and Grants in aid of original research are now awarded annually by the Trust. For particulars, conditions, &c., apply to the Secretary.

UNIVERSITY OF EDINBURGH.

Four degrees in medicine are granted Bachelor of Medicine (M.B.), Bachelor of Surgery (Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). The first two must be taken together, the last two may be taken separately.

No one is admitted to the degrees of Bachelor of Medicine and Bachelor of Surgery who has not been engaged in medical and surgical study for five years, after passing a preliminary examination in general knowledge in accordance with the medical ordinances. A degree in Arts or Science of a British or other recognised University is held to supersede such preliminary examination. The subjects included in this general examination are English grammar and composition, English history and geography, Latin, arithmetic and the elements of mathematics, and Greek, or French, or German.

The *annus medicus* of each year is held to be constituted by at least two courses of not less than one hundred lectures each, or by one of such courses, and two courses of not less than fifty lectures each, exclusive of the clinical courses, in which lectures are given twice a week during prescribed periods. Two years of the five must be spent at the University, the remaining three years at any University of the United Kingdom, or other Universities or Medical Schools recognised by the University Court.

During the first four years the student must attend botany, zoology, physics, practical chemistry, practical physiology, practical pathology, and medical jurisprudence during courses of not less than 2½ months each; public health, not less than thirty lectures; practical anatomy, during two courses of not less than five months each; chemistry, anatomy, physiology, pathology, surgery, materia medica, medicine and midwifery during courses of not less than five months each. Eight of these subjects must be taken at a University or college affiliated to a University entitled to grant the degree of M.D. He must attend a course of twenty-five lectures on practical pharmacy in a University or recognised school of medicine, or have dispensed drugs for a period of three months in a hospital or dispensary, or in an establishment recognised by the Pharmaceutical Society. He must attend a nine months' course in clinical medicine and in clinical surgery. During the fifth or final year he must be engaged in clinical study for at least nine months. In all, before graduation he must have attended for at least three years a hospital which accommodates no fewer than 80 patients, and possesses a distinct staff of physicians and surgeons, and he must have acted as clerk in the medical and dresser in the surgical wards of such a hospital, and attended for six months the practice of a dispensary, or of a physician and surgeon. He must also have had approved opportunities of studying (1) operative surgery; (2) mental diseases at a recognised asylum; (3) at a recognised hospital, *post-mortems*, fevers, and diseases of the eye; and (4) one of the following: Diseases of children, of the ear, nose and throat, or of the skin; (5) vaccination.

He must personally attend at least twelve cases of labour under the superintendence of a registered medical practitioner, or six such cases, and, for at least three months, the practice of a midwifery hospital in which practical instruction is regularly given.

Every candidate must deliver on or before the date for lodging certificates for the final examination to the Dean of the Faculty of Medicine:—

1. A declaration in his own handwriting that he has completed his twenty-first year, or that he will have done so on or before the day of graduation, and that he will not be, on the day of graduation, under articles of apprenticeship to any surgeon or other master. (This declaration, along with a statement of studies, is appended to the schedule for the Final examination, and must be signed before the schedule is given in.)
2. A statement of his studies, as well in literature and philosophy as in medicine, accompanied by proper certificates.

Each candidate is examined both in writing and *viva voce*:—

1. On zoology, botany, physics, and chemistry.
2. On anatomy, physiology, and materia medica and therapeutics.
3. On pathology.
4. On medicine, surgery, midwifery, forensic medicine, and public health.

The examinations in anatomy, chemistry, physiology, botany, and zoology, materia medica and pathology are conducted, as far as possible, by demonstration of objects placed before the candidates.

Candidates who are ready to submit to an examination in the subjects comprised in the first division, *viz.*, botany, zoology, physics, and chemistry, may be admitted to examination in all or any two of these subjects at any examination held after they have attended a full course in each of the subjects professed.

Candidates who have passed their examination in the subjects in the first division may go up for examination in those of the second division at the end of their third winter session, but may postpone their examination in materia medica and therapeutics until the close of the summer session following.

Candidates who have passed the first and second divisions may be examined in the third division at the end of the fourth winter session.

Candidates who have passed their examinations in the subjects comprised in the first, second, and third divisions may be admitted to examination in the fourth or final division, when they have completed the fifth year of study.

The degree of Doctor of Medicine may be conferred on any candidate who has obtained the degrees of Bachelor of Medicine and Bachelor of Surgery, and who is of the age of twenty-four years, and who produces a certificate of having been engaged, subsequently to his having received the degrees of M.B. and Ch.B., for at least one year in attendance on a hospital, or in scientific work bearing directly on his profession, or in the military or naval medical services, or for two years in practice other than purely surgical. The candidate shall submit to the Faculty of Medicine a thesis certified by him to have been composed by himself, and which shall be approved by the Faculty, on any branch of knowledge comprised in the professional examinations for the degrees of Bachelor of Medicine and Bachelor in Surgery, which he may have made a subject of study after having received those degrees. The candidate will also be examined in clinical medicine and must show practical acquaintance with advanced methods of diagnosis; he *may* take, at option, gynæcology, mental diseases, or diseases of children for one of his three cases. The degree of M.D. is conferred on holders of the degrees of M.B., C.M. (Old Regulations), on the submission of a thesis approved by the Medical Faculty, provided that the candidate shall have passed the medical preliminary examination in the subjects of Greek and logic or moral philosophy. Should the candidate elect to do so, he may, however, take the M.D. degree under the new regulations, *i.e.*, substituting an examination in clinical medicine for that in Greek and logic. This course is usually pursued by those who did not pass in these subjects with the rest of their preliminary examinations.

The regulations for the degree of Ch.M. are very similar, the candidate being examined in surgical anatomy, operations on the dead body, clinical surgery, and some of the special branches.

Candidates settled abroad, who cannot appear personally to receive the degree, may, after satisfying the Senatus to that effect, have the degree conferred on them *in absentia*.

Fees:—The fee to be paid for the degrees of Bachelor of Medicine and Bachelor of Surgery is twenty-two guineas, and the proportion of this sum to be paid by a candidate at each division of the examination is registered from time to time in the University Court. The fee for the degree of Doctor of Medicine or of Master of Surgery is ten guineas (Old Regulations, £5 5s.).

The total expense of the curriculum, including examination and matriculation fee, is £146.

Among scholarships, &c., open for competition during Session 1905–6 are the following:—Freeland Barbour Fellowship, £98, anatomy, physiology, and pathology; Allan Fellowship, £51, clinical medicine and surgery; two Vans Dunlop scholarships of £100 for three years, in pathology and materia medica respectively; Stark Scholarship, £110, clinical medicine; James Scott scholarship, £34, in midwifery; Buchanan scholarship, £40, in gynæcology; Mouat scholarship, in the practice of physic, £55; Houldsworth scholarship, in pharmacology, £40; Thomson scholarship, £40—botany and zoology; Sibbald scholarship, £40, subjects of first professional; Ettles scholarship, £30, annually to most distinguished graduate. For details concerning these, and a great number of other prizes, bursaries, research scholarships, and other endowments, see the University Calendar, pp. 481–502.

Graduation in Public Health: Degrees (B.Sc. & D.Sc.) are also conferred in Public Health. Candidates must be graduates in medicine of a University recognised by the University Court, and must matriculate for the year in which they proceed for examination. Before proceeding to the first examination they must produce evidence that (1) they have worked at least twenty hours a week during a period of not less than eight months, after taking their medical degree, in a recognised Public Health laboratory—five of these months must be spent consecutively in the Public Health Laboratory of the University of Edinburgh; and (2) have attended a course of lectures on physics in addition to that qualifying for graduation in medicine, and one, of at least three months' duration, on geology, such as the Senatus may approve of.

Candidates for the second examination of B.Sc. in Public Health are not admitted until at least eighteen months have elapsed after having passed M.B., Ch.B., or sooner than six months after the first examination. They must have attended two separate courses of Public Health, of at least forty lectures each, one dealing with medicine, the other with engineering, each in its relation to public health, in such manner as the Senatus shall determine. They must also have studied practical sanitary work under a Medical Officer of Health for six months, have had three months' clinical instruction in a recognised fever hospital, and three months' instruction in mensuration and drawing.

Full details of the subjects included in the different courses are given in the official programme of the Faculty of Science, which may be obtained from the University (price 2d.).

In a similar manner to that described under degrees in pure science, a B.Sc. may after five years proceed to take the degree of D.Sc. in Public Health.

Fees for Science Degrees: B.Sc., first examination, £3 3s.; B.Sc., second examination, £3 3s.: D.Sc., £10 10s.; total, £16 16s.

Diploma of Tropical Medicine.—Every year an increasing number of candidates avail themselves of the University Diploma of Tropical medicine and Hygiene, which is conferred only on those possessing a degree in medicine. The course of instruction includes practical bacteriology, diseases of tropical climates, tropical hygiene, three months each; practical instruction on the zoological character and life history of disease-carrying insects and venomous animals—one month; clinical instruction at an hospital for tropical diseases—six months. The examination is held in January and July, the fee being £4 4s.

University Hall, Edinburgh.—In an educational number it is worth while to call attention to the advantages now offered to students coming to Edinburgh to study, in the shape of social residences, in which students can live in a self-governing community. In each house there are private studies with or without bedrooms, and common sitting and dining rooms. The charges vary from 7s. 6d. to 22s. 6d. per week. The residents elect a treasurer from among their number who acts as intermediary between them and the housekeeper or servants. It is a satisfactory indication of the comfort of the Hall that many graduates live in it and are willing to help or coach the undergraduates for moderate fees. To gain admission two references must be produced from past or present residents, or other suitable person. These are considered and voted on at a house meeting. The Hall is an admirable place for parents to send their sons to. Any unruly member may be expelled by a meeting of the residents similar to that held for elective purposes.

Medical School for Women.—The medical teaching of women in Edinburgh is carried on by the Scottish Association for the Medical Education of Women (the Secretary, Minto House, Chambers Street). The classes are conducted by the lecturers of the Medical School of the Royal Colleges, and qualify both for the Edinburgh University degree and for the Licence of the

Triple Board. The classes are for women alone. The University of Edinburgh does not recognise certificates presented by female candidates for mixed classes without special cause shown. Women students are eligible for the benefits of the Carnegie Bequest.

UNIVERSITY OF GLASGOW.

The University of Glasgow is both a teaching and an examining body, but admits to examination only those candidates whose course conforms to its own regulations. Within certain limits provision is made for accepting instruction given by recognised medical schools and teachers; but eight of the subjects other than clinical must be taken in this or some other recognised University entitled to confer the degree of M.D., and at least two years of the course must be taken in Glasgow University. Under the new regulations, laid down in Ordinance No 14, Glasgow No. 1, of the Commissioners under the Universities (Scotland) Act, 1889, four degrees, open both to men and to women, are conferred—M.B. and Ch.B. (always conjointly), M.D. and Ch.M. A preliminary examination must be passed in (1) English, (2) Latin, (3) Elementary mathematics, and (4) Greek, French, or German, with possible option to students whose native tongue is not English in the case of the fourth subject, and on passing, students must register in the books of the General Medical Council. By a regulation recently enacted, it is no longer compulsory to pass in all the four preliminary subjects at once, and they may now be passed at two stages. For M.B. and Ch.B. a curriculum of five years is required. A syllabus with full details of the curriculum and of the preliminary examination may be had, post free, on application to the assistant clerk, Matriculation Office.

The fees for M.B. and Ch.B. are £23 2s.; for M.D. £10 10s., and for Ch.M. £10 10s. For hospital attendance there is an initial fee of £10 10s., with a further fee of £3 3s., for each winter session, and £2 2s. for each summer session of clinical instruction. There are three very extensive general hospitals in the city, which afford exceptional opportunities for clinical work, while the Royal and other asylums, the City Fever Hospitals, the Maternity Hospital, the Sick Children's Hospital, the Eye Infirmary, &c., give facilities for the study of special branches.

The degrees of B.Sc. and D.Sc. in Public Health are also now conferred. Of late the University has made considerable efforts to extend its laboratory accommodation and equipment, to augment its teaching staff, and to encourage post-graduate and research work. Within the last few years there have been provided new laboratories in the departments of pathology, anatomy (costing £13,000), chemistry, and surgery (costing £9,900); while new laboratories, to cost, with equipment, upwards of £60,000, are now in course of erection for the departments of physiology, materia medica, and medical jurisprudence and public health.

Bursaries and prizes to the annual amount of about £900 are appropriated to medical students, including an Arthur bursary for women, £20 for three years.

Several bursaries open to students in any faculty are not infrequently held by medical students, and Scholarships and Fellowships to the annual amount of £1,600 may be held by medical students who have gone through the Arts course.

Queen Margaret College for Women. — Founded in 1883 (by the Glasgow Association for the Higher Education of Women, which was formed in 1877 with the object of bringing University instruction, or its equivalent, within the reach of women), Queen Margaret College in 1890 added to its faculty of Arts a School of Medicine for Women. This was organised entirely on University lines, and with the view of preparing for University degrees; and when, in 1892, in consequence of the Ordinance of the University Commissioners authorising the Scottish Universities to admit women to instruction and graduation, Queen Margaret College became the Women's Department of the University of Glasgow, its classes in medicine taken previously to its incorporation with the University were recognised as preparing for the degree. A full course of study for M.B. and Ch.B. is given by University professors and lecturers, with excellent facilities for hospital and dispensary work in the Royal Infirmary and other hospitals. A Hall of Residence for the students was founded in 1894. Fees for the classes at Queen Margaret College may be paid by the Carnegie Trustees.

UNIVERSITY OF ABERDEEN.

The University of Aberdeen possesses under its charters the amplest privileges claimed or enjoyed by any academical institution. It confers degrees in the five faculties of Arts, Science, Divinity, Law, and Medicine. It also grants diplomas in Public Health, Agriculture, and in Education. It is, moreover, a teaching body equipped with twelve distinct chairs in the various branches of medicine and surgery, besides a Lectureship in Tropical Medicine. The majority of the professors devote their whole time to the work of the chairs. There are fully-equipped laboratories, the accommodation for which has recently undergone considerable extension. The degrees of M.B. and Ch.B. are conferred together; they cannot be obtained separately. The curriculum of study is nearly the same as in the University of Edinburgh; the regulations in the preceding columns will therefore apply here. Two years must be passed at Aberdeen. With regard to fees, each candidate for the degrees of M.B. and Ch.B. must pay a fee of £5 5s. in respect of each of the first three professional examinations, and £7 7s. for the final examination. Total cost, exclusive of the fees for degrees, is about £130. Besides the Royal Infirmary students have the opportunity of attending several other local institutions where special courses of instruction are given. Perpetual fee for hospital practice is only £6. The professional examinations are held twice in each year, namely, in March and July, directly after the close of the winter and summer sessions.

BURSARIES.—Bursaries, Scholarships, and Fellowships to the number of fifty, and of the annual value of over £1,180, may be held by students of medicine. (See "University Calendar.")

THE DEGREE OF M.D.—The degree of Doctor of Medicine may be conferred on any candidate who has obtained the degrees of M.B. and C.M. (Old Regulations), is of the age of twenty-four years, and has been engaged subsequently to his having received the degree of M.B. for two years in attendance in a hospital, or in military or naval medical service, or in medical or surgical practice, and has presented a thesis which has been approved of by the Medical Faculty. Candidates for the degree of M.D. (New Regulations) are required to pass an examination in clinical medicine in addition to presenting a thesis. Similar regulations apply to a degree of Ch.M. (Master of Surgery).

A Diploma in Public Health is conferred after examination on graduates in medicine in any University in the United Kingdom. Regulations may be seen in the "Calendar," or obtained on application to the Secretary the Medical Faculty.

Aberdeen Royal Infirmary.—This is a well-equipped institution, containing 250 beds, and affords excellent opportunities for clinical study to students at the Aberdeen University. The city, moreover, offers inducement in the way of cheaper living and comparative quiet to that obtained in Edinburgh and Glasgow, and will doubtless be preferred by some on this account.

ST. ANDREWS UNIVERSITY.

UNITED COLLEGE ST. ANDREWS AND UNIVERSITY COLLEGE, DUNDEE.

This University (session opens October 7th) grants the degrees of M.B., Ch.B., M.D., and Ch.M. The degrees of the University are open to either sex. For the degree of M.B., Ch.B., two of the five years of medical study must be spent in the University of St. Andrews; the remaining three may be spent in any University of the United Kingdom, or in any foreign, Indian, or Colonial University recognised for the purpose by the University Court, or in such medical schools or under such teachers as may be recognised for the purpose by the University Court. The preliminary examination and the professional examinations are of the same character as in the other Scottish Universities. A Diploma in Public Health is also granted by the University of St. Andrews to graduates in medicine of any University in the United Kingdom. Twelve months must elapse between the date of graduating in medicine and entering for the examinations for the diploma. The course of study required consists of (1) a six months' course of practical chemistry, bacteriology, and the pathology of diseases transmissible from animals to man in a laboratory of the University of St. Andrews; (2) six months' work with a medical officer of health; (3) three months' clinical instruction in infectious diseases. Subjects for first examination:—Chemistry, physics, bacteriology, and meteorology. Second examination:—Sanitation, sanitary law, vital statistics, medicine in relation to public health.

University College, Dundee, was affiliated and made to form part of the University of St. Andrews on January 15th, 1897, and the whole medical curriculum may be taken in the College. The United College, St. Andrews, offers classes for the first two years of professional study.

BURSARIES AND SCHOLARSHIPS.

United College, St. Andrews.—Malcolm bursary £25 a year, tenable for five years). Fourteen Taylour Thomson bursaries, £30 to £20, five tenable for one year, nine for two, open to women only proceeding to graduate in medicine.

University College, Dundee.—Eleven entrance bursaries of £15, open to women for arts, science, or medicine, tenable for one year. Four £20 and three £15 second year bursaries for men or women in arts, science, or medicine, tenable for one year. Four £20 and two £15 third year bursaries for men or women in arts, science, or medicine, tenable for one year. Two Educational Trust bursaries of £25, tenable for three years. Applicants must have attended a public or State-aided school in Dundee for at least one year before examination. Bute bursary, annual income from £1,000 (men only).

Preliminary Examinations.—The dates of the next two examinations are September 29th, 1905, and March 23rd, 1906. Schedules (obtainable from the Secretary of the University) to be returned filled up, and fees paid by September 16th, 1905, or March 7th, 1906.

Fees for Degrees.—Total fees for M.B., Ch.B., are the same as at other Scottish Universities, *i.e.*, 22 guineas (payable in instalments). Fee for the degree of M.D., and also for that of Ch.M., is 10 guineas in each case. For the Diploma of Public Health examinations the fee is £5 5s. for each of the two examinations.

Class Fees.—The fee payable in each of the following classes is 4 guineas, *viz.*:—Chemistry, physics, zoology, botany, physiology, anatomy, materia medica, pathology, forensic medicine, and public health, medicine, surgery, and midwifery. The fee for the practical classes in these subjects is 3 guineas each. In clinical surgery, clinical medicine, ophthalmology, diseases of the throat, nose, and ear, and mental diseases, the class fees are 2 guineas each. The fee for Public Health chemistry required for the D.P.H., is £7 7s. A special class in Bacteriology is also held for the D.P.H. for which the fee is 3 guineas.

Dundee District Asylum.—The appointments include a qualified resident assistant and two resident clinical clerks. Clinical instruction is given.

Further information will be found in the Calendar of the University, published by Messrs. Blackwood and Sons, Edinburgh, or can be had of the Dean of the Medical Faculty, Professor Waymouth Reid, F.R.S.

Dundee Royal Infirmary.—The Infirmary contains 300 beds, with a special ward for the treatment of children. Three resident qualified assistants are appointed annually. Clinical clerks and dressers are attached to the physicians and surgeons, and students are appointed to assist in the post-mortem room. Outpatients are seen daily at 9 a.m. The instruction given at the Infirmary is recognised for purposes of graduation by the Scotch Universities, the University of London, the University of Cambridge, the Royal University of Ireland, and by the Royal Colleges of England and Scotland. Hospital Ticket for the Infirmary, £2 2s. each session, or £3 3s. a year. Further information on application to the Medical Superintendent.

THE COLLEGES.

The Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow have made arrangements by which, after a series of examinations, the student may obtain the diploma of the co-operating bodies.

The holders thereof are enabled to register three diplomas under the Medical Acts, *viz.*, Licentiate of the Royal College of Physicians of Edinburgh, Licentiate of the Royal College of Surgeons of Edinburgh, and Licentiate of the Faculty of Physicians and Surgeons of Glasgow. The diplomas are also recognised by the Army, Navy, and other public bodies.

The three co-operating bodies grant their *single* qualifications only to candidates who are already registered as possessing another and opposite qualification in medicine and surgery, as the case may be.

REGULATIONS OF THE CONJOINT BOARD OF THE ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH AND THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH AND THE FACULTY OF PHYSICIANS AND SURGEONS, GLASGOW.—The candidate must produce certificates of having attended the following separate and distinct course of lectures, the certificate distinguishing the sessions and the schools in which the courses were severally attended. Anatomy, one course, six months. Practical anatomy, twelve months. Chemistry, one course, six months. Practical or analytical chemistry, one course, three months. Materia medica, one course, three months. Physiology, one course, six months. Practice of medicine, one course, six months. Clinical medicine, nine months. Principles and practice of surgery, one course, six months. Clinical surgery, nine months. Midwifery and diseases of women and children, one course, three months. Medical jurisprudence, one course, three months. Pathological anatomy, one course, three months. The candidates must also produce the following certificates:—(*a*) Of having attended not less than six cases of labour under the superintendence of the practitioner who signs the certificates, who must be a registered medical practitioner. (*b*) Of having attended for three months' instruction in practical pharmacy. The certificate to be signed by the teacher, who must be a member of the Pharmaceutical Society of Great Britain, or the Superintendent of a laboratory of a public hospital or dispensary, or a registered practitioner who dispenses medicine to his patients, or a teacher to a class of practical pharmacy. (*c*) Of having attended for twenty-four months the medical and surgical practice of a public general hospital, containing on an average at least eighty patients, and possessing distinct staffs of physicians and of surgeons. (*d*) Of having attended, for six months, the practice of a public dispensary specially recognised by any of the co-operating bodies; of having been engaged for six months as visit-assistant to a registered medical practitioner. (*e*) Of having been instructed in vaccination.

First Examination, Fee £5.—The first examination shall embrace chemistry, comprising the following particulars:—Chemical physics, heat, light, and electricity; the principal non-metallic and metallic elements, and their more common combinations, also the leading alcohols, organic acids, ethers, carbohydrates, and alkaloids; the candidates will also be examined practically in testing; physics and elementary biology. The first examination shall take place not sooner than the end of the first year, including a winter and summer session. Candidates who desire to enter for the first professional examination must apply to the Inspector of Certificates on or before the Friday preceding the day of examination, and must produce certificates of attendance on one course of chemistry, one course of practical chemistry, one course of anatomy, and six months' practical anatomy.

Second Examination, Fee £5.—The second examination shall embrace anatomy and physiology, and shall not take place before the termination of the summer session of the second year of study. Candidates must produce to the Inspector certificates of attendance on the prescribed courses of anatomy, practical anatomy, and physiology.

Third Examination, Fee £5.—Comprises the subjects of pathology, materia medica, and pharmacology and advanced anatomy.

Final Examination, Fee £15.—The Final examination shall embrace the principles and practice of medicine (including therapeutics and medical anatomy, clinical medicine); the principles and practice of surgery (including surgical anatomy and surgical pathology); clinical surgery; midwifery and gynæcology, medical jurisprudence and hygiene; and shall not take place before the termination of the full period of study.

Subjects of Preliminary Education: (1) English language, including grammar and composition; (2) Latin, including grammar, translation from specific authors, and translation of easy passage not taken from such authors; (3) elements of mathematics, comprising (*a*) arithmetic, including vulgar and decimal fractions; (*b*) algebra, including simple equations; (*c*) geometry, including the first two books of Euclid; (4) elementary mechanics of solids and fluids, comprising the elements of statics, dynamics, and hydrostatics; (5) one of the following optional subjects:—(*a*) Greek; (*b*) French; (*c*) German; (*d*) Italian; (*e*) any other modern language; (*f*) logic; (*g*) botany; (*h*) zoology; (*i*) elementary chemistry.

Qualification in Public Health: The College of Physicians, in association with the Royal College of Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, confers a certificate of competency in public health. The examinations are held in April and October. Fee, £10 10s.

For the special regulations of the Royal College of Surgeons of Edinburgh, intending candidates should apply to Mr. James Robertson, 48 George Square, Edinburgh; and for those of the Royal College of Physicians, to Dr. H. Rainy, 16, Great Stuart Street, Edinburgh.

The Fellowship of the Royal College of Physicians of Edinburgh is conferred only by election, and the candidate must have been a member of the college for at least three years previously, and have attained the age of twenty-seven years.

The Membership is conferred only on a licentiate of a college of physicians or graduate in medicine of a British or Irish University, provided he shall have attained the age of twenty-four years and shall have passed an examination (1) On the principles and practice of medicine, including therapeutics; (2) on one of the following subjects to be selected by the candidate, *in which a high standard of proficiency is expected*:—(*a*) one or more departments of medicine specially professed; (*b*) psychological medicine; (*c*) pathology; (*d*) medical jurisprudence; (*e*) public health; (*f*) midwifery; (*g*) gynæcology. The examination is of a searching character extending over three days, the first of which is devoted to the examination of patients *viva voce*, and practical examination on methods of diagnosis —*e.g.*, microscopy of blood, clinical bacteriology, quantitative analysis, &c., and written commentary on a case examined. The second day is taken up by written papers, and the third by practical examination on special subject and orals.

The fee for membership is 35 guineas, for fellowship 38 guineas, with a stamp duty of £25—£101 13s. in all.

The licence, or single qualification in medicine, is conferred on candidates who already possess a recognised qualification in surgery. The examinations for this licence are held on the first Wednesday of each month, save those of September and October, in medicine, materia medica, midwifery, and medical jurisprudence. The fee is £15 15s., and intending candidates should communicate with the Secretary of the College at least eight days before the date of examination.

The Fellowship of the Royal College of Surgeons of Edinburgh is conferred (except under certain conditions as to age and professional standing) only on candidates who have passed a special examination, and have previously obtained a diploma from the college, or from either of the Colleges of Surgeons of England or Ireland, or the Faculty of Physicians and Surgeons of Glasgow, or the surgical degrees of the Universities of Great Britain, and who are twenty-five years of age. The subjects for examination for those who are already Licentiates of the College are on the principles and practice of surgery, clinical and operative surgery, and one optional subject.

Those who are not Licentiates of this College: on principles and practice of surgery, clinical and operative surgery, surgical anatomy, and one optional subject: and in such supplementary subjects as have not, in an adequate manner, been included in the examination for the registrable surgical qualification possessed by such candidates, and which are required in the examination for Licentiates of this College.

The optional subjects shall embrace: (*a*) Surgery, special branches; (*b*) advanced anatomy and physiology; (*c*) surgical pathology and morbid anatomy; (*d*) midwifery and gynæcological medicine and surgery; (*e*) medical jurisprudence and hygiene; (*f*) practice of medicine and therapeutics. The examinations are written, oral, and practical. Three weeks' notice must be given to Mr. James Robertson, from whom full particulars as to certificates required may be obtained. The fee is £30 for those who hold the diploma of Licentiate of the College, and £45 to others (no stamp duty is payable on the diploma). Registered practitioners, aged not less than 40, who have been in practice for not less than ten years, and who have highly distinguished themselves by original investigations, may under special circumstances be elected without examination. Women are not admitted to the Fellowship.

LICENCE.—The examination embraces the principles and practice of surgery (including operative surgery and surgical pathology), clinical surgery, and surgical anatomy, and shall not take place before the termination of the full period of study. Fee, £15 15s.

DENTAL DIPLOMA.—Every candidate for the dental diploma must have attended the general lectures and courses of instruction required at a University or an established medical or dental school recognised by the College as qualifying for the diploma in surgery. The fee is £10 10s.

Edinburgh Royal Infirmary.—Clinical instruction is afforded at this institution, which contains 800 beds under the supervision of professors of the University and the ordinary physicians and surgeons of the Infirmary. Special instruction is given on diseases of women, physical diagnosis, diseases of the skin, eye, ear, throat and teeth, and anæsthetics. Separate wards are devoted to venereal diseases, diseases of women, diseases of the eye, also to cases of incidental delirium or insanity, and three wards are specially set apart for clinical instruction to women students. Post-mortem examinations are conducted in the anatomical theatre by the pathologists. The perpetual fee, on one payment, £12; the annual fee, £6 6s.; half-yearly, £4 4s.; quarterly, £2 2s.; monthly, £1 1s. Separate tickets amounting to £12 12s. entitle the student to a perpetual ticket. No fees are payable for any surgical or medical appointment.

The appointments are as follows:—

1. Resident physicians and surgeons are appointed and live in the house free of charge. There is no salary. The appointment is for six months.
2. Non-resident physicians and surgeons (in the special subjects and for out-patient work) are appointed for six months. These appointments may be renewed.
3. Clerks and dressers are appointed by the surgeons and physicians. These are open to all students and junior physicians holding hospital tickets.
4. Assistants in the pathological department are appointed by the pathologists to conduct post-mortem examinations in the anatomical theatre.

SCHOOL OF MEDICINE OF THE ROYAL COLLEGES, EDINBURGH.

The government of this school, established in 1505, is now vested in a board which is equally representative of the two Royal Colleges and the Lecturers, the school being styled "The School of Medicine of the Royal Colleges, Edinburgh." The present number of lecturers is about sixty, of whom the greater number deliver qualifying courses of instruction of the same duration and scope as those delivered within the University, while a large number of non-qualifying courses on special subjects of interest to medical science, but which are not required for graduation, are delivered both in the winter and summer sessions. The students who attend the classes of the School of Medicine are largely students proceeding to the University degree, as well as those who are intending to take other qualifications, such as the triple qualification of the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow; that of the Royal College of Physicians of London, and the Royal College of Surgeons of England, and the degrees of the different Universities. The number of students attending the school averages 1,300 annually.

The minimum cost of the education in the School of Medicine for the triple qualification of physician and surgeon from the Royal Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, including the fees for the joint examinations, is about £120, which is payable by yearly instalments during the period of study.

The Winter Session opens October 2nd.

GLASGOW EXTRA-MURAL SCHOOL.

St. Mungo's College and Glasgow Royal Infirmary.—This college was incorporated in 1889 under its new title, being formerly known as the Glasgow Royal Infirmary School of Medicine. The Medical Faculty occupies buildings erected for the purpose of the medical school in the grounds of the hospital, and the laboratories, museums, and lecture rooms are of the most approved description. The college has been recently equipped with a complete electric light installation, and a powerful electric educational lantern. Attendance on the classes in St. Mungo's College qualifies for the medical degrees of the Universities and the medical and surgical colleges in accordance with their regulations.

The Royal Infirmary, which is at the service of the College for teaching purposes, is one of the largest general hospitals in the kingdom. It has over 600 beds available for clinical instruction, including an ophthalmic department, and it has special wards for diseases peculiar to women, for venereal diseases, erysipelas, burns, and diseases of the throat. At the dispensary special advice and treatment are given in diseases of the eye, ear, teeth, and skin, in addition to the large and varied number of ordinary medical and surgical cases—about 78,000 per annum—which in a great industrial centre daily require attention. Students at the college and hospital get the benefit of dispensary experience free of charge, and no better or wider field for seeing hospital practice and receiving clinical experience can be found than in the Glasgow Royal Infirmary.

Appointments.—All appointments are open. There are five physicians' and eight surgeons' assistants, who obtain free board and residence in the hospital and act in the capacity of house physicians and house surgeons. There is also a house surgeon for the ophthalmic department. These appointments are made for six months, and are open to gentlemen who have a legal qualification in medicine and surgery. Clerks and dressers are appointed by the visiting physicians and surgeons. From the large number of cases of acute diseases and accidents of varied character received, these appointments are valuable to students. In the pathological department assistants are also appointed by the pathologist.

Fees.—The fees for Lectures, including Hospital attendance necessary for candidates for the Diplomas of the English, Scotch, and Irish Colleges of Physicians and Surgeons, amount to £67.

Anderson's College Medical School, Glasgow.—New and excellently equipped buildings were opened in October, 1887, in Dumbarton Road, immediately to the west of the entrance to the Western Infirmary, and within four minutes' walk of the University. Extensive laboratory accommodation is provided for practical anatomy, practical chemistry, practical botany, practical zoology, practical physiology, practical pharmacy, operative surgery. There are also provided a library and reading room, and students' recreation room. The buildings are constructed upon the most approved modern principles. The dissecting room is open in winter from 9 a.m. to 6 p.m., and in summer from 6 a.m. to 6 p.m. These students are assisted in their dissections by the professor and demonstrators, by whom daily examinations and demonstrations on the parts dissected are conducted. The supply of subjects is ample, and students are consequently provided with parts as soon as they may be ready for them. The dissecting room is provided with a complete series of dissecting specimens mounted in plaster of Paris illustrating the anatomy of the human body. There is also a large Bone Room, furnished with complete sets of painted and unpainted bones.

The Carnegie Trust pays the fees of students at Anderson's College on conditions regarding which particulars may be obtained from W. S. McCormick, Esq., LL.D., Carnegie Trust Offices, Edinburgh.

Class Fees.—For each course of lectures (anatomy, ophthalmic medicine and surgery, aural surgery, diseases of throat and nose, and mental diseases excepted), first session, £2 2s.; second session (in Anderson's College), £1 1s.; afterwards free. For the following practical classes, viz.: Chemistry, botany, zoology, physiology, pharmacy, first session, £2 2s.; second session, £2 2s.; in botany and zoology, practical and systematic course together, £3 3s. Operative surgery, £2 2s.; laboratory fee, 10s. 6d. Public health laboratory, £11 11s.; with lecture, £12 12s.

Anatomy Class Fees.—Winter: First session (including practical anatomy), £4 4s.; second session (including practical anatomy), £4 4s.; third session, £2 2s. To those who have had the necessary courses of practical anatomy, the fee will be £1 1s. Summer: Lectures and practical anatomy, £2 12s. 6d; separately, £1 11s. 6d. each.

Western Infirmary.—Fees: Hospital attendance £10 10s. (permanent); clinical instruction, winter £3 3s., summer £2 2s., pathology, £4 4s. (systematic), practical pathology, £3 3s.; vaccination, £1 1s.

Royal Infirmary.—Fees: Hospital practice and clinical instruction, first year, £10 10s.; second year, £10 10s.; afterwards free. Six months, £6 6s.; three months, £4 4s.; pathology, both courses, £4 4s.; vaccination fee £1 1s.

Dental Curriculum.—Students studying with a view to the dental diploma can obtain instruction in the following subjects: Physics, chemistry, anatomy, physiology, surgery, practice of medicine, and materia medica. The special dental courses may be obtained in the Dental School, 15, Dalhousie Street, Glasgow. Particulars may be had from D. M. Alexander, Esq., 97, West Regent Street.

POST-GRADUATE COURSES IN SCOTLAND.

In Edinburgh a number of post-graduate courses continue more or less throughout the year.

In Glasgow, special courses in ear diseases are held in November and May at Anderson's College, and Post-graduate courses in pathology and bacteriology at the University in autumn.

[End of the Educational Number.]

His Majesty the King, who left Marienbad last week, had a special interview with Dr. Ernest Ott, the Austrian physician who has been in attendance on his Majesty, and presented him with a magnificent clock standing six feet high, in recognition of his services.

Notes on Current Topics.

Mr. Troutbeck and the Provinces.

It need hardly be pointed out in the columns of a medical journal that the outcry against Mr. Coroner Troutbeck's methods is founded on principles that apply all over the kingdom. In proof of that proposition comes a unanimous resolution from the Monmouth division of the British Medical Association to the following effect :—

"That the Monmouthshire Division of the British Medical Association, on behalf of the members of the medical profession in the County of Monmouth, hereby places on record its earnest protest against the attitude of indifference to the opinion of the medical profession adopted by His Majesty's present Government, and specially indicated by the failure of the Lord Chancellor to give judgment in the case submitted to him by the British Medical Association concerning the procedure of the coroner for South-West London, and the omission of the Prime Minister for twelve months to reply to the formal communications of the Association in reference thereto."

It is interesting to speculate what would have happened had the legal profession been flouted in a similar way. However much it may be desirable to keep politics and professional matters apart, it is, nevertheless, impossible to avoid recognising the fact that an injustice inflicted upon so important a class of the community as that of the medical world is likely to have some influence at the polls.

Re-organisation of the Irish Medical Association.

In our issue of Wednesday next, we shall commence a special series of signed articles by prominent members of the Irish Medical Association, in which the writers will deal with the proposed re-organisation of the Association, in all its aspects. The first article of the series will be contributed by Dr. R. J. Kinkead, a former President of the Association, and the existing President of its Connaught Branch, and he will be followed by Dr. R. B. Mahon, who will contribute an article to our issue of September 27th. Among other contributors who have kindly promised articles are Dr. Greene, of Ferns, a late Vice-President of the Association; Dr. Leeper, late Honorary Secretary to the Council of the Association; and Dr. R. M. Blake, President of the Poor-law Officers' Association. These names guarantee that every aspect of the question of re-organisation will be discussed. As re-organisation of the Association is the burning question of the moment, so far as the medical profession in Ireland is concerned, a careful perusal of this important series of articles will be essential in the case of all medical men who take an active interest in the future of the Association.

Like Master, Like Man.

We notice from the report of an inquest that we have before us that the spirit in which the work of the coroner for South-West London has been performed of late is likely to become a definite tradition to be followed by others. We had hoped that that tone of hauteur and superiority adopted towards medical witnesses, and the disregard paid to their proferred evidence, was to be confined to Mr. Troutbeck, but in his absence the deputy-coroner, Mr. Wellington, seems loyally to be supporting him. In the case under notice a tobacconist was found with his throat cut on Clapham Common, and the police summoned to their assistance a neighbouring practitioner. Dr. Greene. With great assiduity Dr. Greene examined the body and its surroundings, spending an hour in his investigations. It need hardly be said that Dr. Freyberger was called in to do the post-mortem and give evidence, and when the coroner was about to sum up, Dr. Greene called attention to the fact that his own evidence had been ignored, and that he did not consider that the case had been properly investigated. The deputy-coroner told Dr. Greene that he could not listen to his statement in open court, but that if he liked to raise any question of principle he would see him in his private room. The hollowness of this offer was shown by Dr. Greene stating that he had already written to the Coroner and had not even been accorded the courtesy of a reply. The Coroner said that he did not know about the letter —a sufficient comment in itself on the way the Court is conducted.

PERSONAL.

It is announced that the Emperor of Austria has appointed Dr. Karl Toldt, Professor of Anatomy in the University of Vienna, a life member of the Austrian House of Lords.

The Graefe Medal of the Ophthalmological Congress which held its annual meeting in August last, was awarded to Professor Hering, of Leipzic, for his work in physiological optics.

Fleet-Surgeon J. Lloyd Thomas, R.N., of the "Excellent," is to represent the Medical Department of the British Royal Navy at the Military Medical Congress to be held at Detroit at the end of this month.

At the same Congress, the Medical Department of the British Army will be represented by Lieutenant-Colonel Rainsford, C.I.E., R.A.M.C., Principal Medical Officer, Bermuda. The Indian Medical Service will also be represented.

The will of the late Mr. Christopher Heath has been proved at £7,799.

Professor Podwyssotzki, Dean of the Medical Faculty of Odessa, has been appointed Director of the Institute for Experimental Medicine at St. Petersburg.

A medical exhibition on a large scale has been organized by the *British and Colonial Druggist*, to be held in the New Horticultural Hall, Vincent Square, Westminster, on October 2nd, 3rd, 4th, 5th, and 6th.

A discussion on pure milk supply will be opened by Mr. C. W. Sorensen at a provincial session of the Royal Sanitary Institute, in conjunction with the Yorkshire Branch of the Incorporated Society of Medical Officers of Health at York on October 7th.

Professor H. R. Kenwood will deliver the introductory lecture at University College, London on Monday, October 2nd, at 4 o'clock, on "Preventive Medicine—Past and Prospective."

The annual prize distribution will be made at the Charing Cross Hospital Medical School, and an address delivered by Sir James Crichton-Browne, M.D., LL.D., F.R.S.., on Monday, October 2nd, at 4 o'clock.

Professor E. C. Stirling, C.M.G., M.D., F.R.C.S., F.R.S., is President-Elect of the Australasian Medical Congress for 1905, in place of the retiring president, the Hon. G. H. Butler, M.R.C.S., L.R.C.P., Hobart.

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, September 9th, 1905.

A New Method of Resuscitation in Children born Asphyxiated.

Dr. O. Kaiser, of Dresden, describes his method in the *Frauenarzt H.*, 232. From appearances, it is simple, much less fatiguing to the operator, and it has the further advantage that the new-born infant is kept warm. With these advantages in its favour it at least deserves some consideration.

The child is grasped in the same way as in the Schultze method of swinging used for the same purpose, *i.e.*, from behind, with the hands over the child's shoulders, thumbs in front. Of course, the usual clearing of the mouth, &c., is not omitted. It is then dipped as far as the breast into a tub of warm water, and here receives the back and forward movements of artificial respiration, carried out at the usual rate of infantile breathing. Without loss of time or warmth, the child may be dipped more or less deeply as seems desirable, but the resuscitation is the better the higher the child is raised out of the water. It seems not improbable, says the writer, that the back and forward movement affects not only the lungs, but also excites the heart as a kind of heart massage, as is often practised in adults in impending death from chloroform. He also observes rather shrewdly that the procedure has a better look than the old one as far as the onlooking laity are concerned—even that is something.

At the Gesellschaft der Charite-Aerzte, Hr. Ziehen showed a patient who, without any physiological or pathological motive had attempted to commit

Suicide.

The older psychiatry designated such cases as delirium or, in case of repetition, as *folies des actes*, or "moral insanity"; the newer as *les impulses par heredite*. In moral insanity there was defect of intelligence; in dementia præcox the acts were mostly secondary; but here they were primary, impulsive, without any previous play of motive. The cause was almost always a simple hereditary taint. In the present case both father and grandfather committed suicide. The ideas were not inherited, but the mode of reaction—here the affective and the impulsive idea that invited to suicide. Such cases had a forensic interest, as the aggressive were not always directed against the person of the individual affected (sexual crime, arson, bodily wounding). The prognosis was bad; other attempts of a similar kind generally followed.

Austro-Hungary.

[FROM OUR OWN CORRESPONDENT.]

Budapest, September 9th, 1905.

At the International Congress on Anti-Alcoholism, held here on Sept. 7th, Dr. Hollos read a paper on the Influence of Parental Inebriety on the Offspring.

The pernicious influence on the offspring of habitual parental inebriety is a well-recognised factor in pathology, and statistics seem to show that this cause is vastly more operative when of the two parents the mother is the drunkard. This, indeed, is only what one would anticipate, seeing that for nine months the fetus remains exposed to the perilous influence of the alcohol, taken persistently. Sobriety on the part of the father has but little effect so far as the health and vitality of the child is concerned, and in presence of maternal drunkenness, may at most be discarded, although no doubt the result of the two bad strains would intensify the consequent mischief. The influence of chronic parental inebriety in this connection bears mainly on the higher department of the nervous system, producing more or less marked intellectual inferiority and a functional incapacity on the part of what may be described generally as the moral functions of the brain. For instance, the children of drunken mothers have but an imperfect conception of the moral obligation of honesty, truth, etc., in spite of careful training, which, by the way, they do not usually get. Their emotions and passions cannot be brought under adequate control; consequently they furnish a large contingent to the criminal, and to what the criminologist would call the irresponsible classes. Looked at from this point of view it becomes obvious that criminal tendencies are of the nature of a constitutional disease, to be dealt with preventively and therapeutically.

Correspondence.

"DEFENDED LAW AND DEFENCELESS MEDICINE."

To the Editor of The Medical Press and Circular.

Sir,—Your leader under the above heading this week suggests some painful reflections. There can be no doubt, to say the least, that the injury inflicted upon the public by the practice of medicine for gain by unqualified persons fully equals any injury which could be caused by unqualified practitioners acting as solicitors. Legislation exists which completely protects the public from the latter danger; it is evident similar protection could be provided against the former. While your article was going through the press, a case in a London police court was reported exemplifying for the ten-thousandth time the efficacy of the protection afforded to lawyers. The culprits in this case were a firm carrying on a business in which, among other things, they undertook to conduct legal processes. They had assumed no title implying that they were qualified, nor did it appear that there was any close approach to false pretence in this respect; nevertheless, they were heavily fined. Medical quacks cannot with impunity assume titles enumerated in the Medical Act; but they can and do assume sham titles, and employ language in their advertisements which leaves no doubt upon the minds even of the intelligent public that the quacks are legally qualified practitioners. In every direction in which the public can be imposed upon, and where the danger of a verdict of manslaughter for malpractice is slight, medical quacks are to be found flourishing in numbers, and no law exists by which they can be interfered with. This state of things simply shows how powerless, politically, the medical profession remains. In spite of the British Medical Association, a vast organised mass of practitioners able, one would think, to make their united voice heard as loudly and effectively as an equal number of lawyers, no attempt whatever is made to remedy the evils which your article discusses, nor to diminish the disabilities and grievances under which our profession labours, which, as can easily be proved, are equally detrimental to the interests of the people.

I am, Sir, yours truly,

Sept. 7th, 1905. An Obscure Practitioner.

Obituary.

PHILIP HENRY MULES, M.R.C.S., M.B., OF WREXHAM INFIRMARY.

We regret to announce the death at the age of 62, of Dr. Mules, at his residence, Gresford, Denbighshire, on September 1st. Dr. Mules was a student at St. George's Hospital, London, and in Edinburgh, where he took the degree of M.B. in 1870. After some years in general practice, Dr. Mules specialised in eye diseases, and soon became known as a skilful ophthalmic surgeon. In 1884, he gained the Prize Medal of the International Society for the Amelioration of the Condition of the Blind, awarded by the Paris Society. While in Manchester, Dr. Mules was Surgeon to the Manchester Royal Eye Hospital, and Altrincham General Hospital. In Altrincham he practised for many years. On leaving Manchester he took up his residence in Gresford, and his practice extended to Chester and Wrexham. Some years ago Dr. Mules succeeded the late Dr. Charnley as Ophthalmic Surgeon at the Wrexham Infirmary. Dr. Mules made many contributions to medical literature. His best known contribution was in 1885 on evisceration of the globe and the introduction of an artificial vitreous tumour, consisting of a light aluminium ball. Dr, Mules leaves a widow, two sons, and four daughters.

Notices to Correspondents, &c.

☛ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," 'Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

NOTICE TO HOSPITAL AND COLLEGE DEANS.

The Editor desires to thank those gentleman attached to the various Schools and Hospitals for supplying him with the information from which the foregoing pages have been composed.

NOTICE TO OUR READERS.

As this number is mainly devoted to information necessary for students intending to join one or other of the various medical colleges, and for those who, having passed their curriculum, are about to enter the ranks of the profession, much of the ordinary matter which usually fills our columns is necessarily deferred till next week.

GRATUITOUS COPIES.

A very large number of copies of this issue are being sent gratuitously to all the educational establishments, hospitals, reading-rooms, clubs, and large hotels, in the United Kingdom, and to a large number in America, India, the Colonies, and on the Continent; should any of our readers desire to present a copy to a patient or friend who contemplates sending his son to a medical school, our publisher will be happy to supply him with a duplicate free of cost on receipt of address.

Letters from our Paris, Belfast, Edinburgh, and Vienna correspondents, and several communications from others, are unavoidably held over this week on account of the space devoted to educational matters.

THE INTERNATIONAL SURGICAL SOCIETY'S CONGRESS AT BRUSSELS.

We are asked by Mr. Reginald Harrison to announce that elected members of the International Surgical Society who purpose attending the first International Surgical Congress at Brussels during the week commencing on the 18th inst., that a general meeting of the Association will then be held to appoint the International Committee, to select subjects for discussion and readers of papers, to fix the next place of meeting, and to elect the president. A considerable number of members from various countries have already announced their intention of being present. The Belgian Committee will be pleased to send invitations to Fêtes, &c., in honour of Foreign Members of the Society attending the Congress, on hearing from them. Intimations should be sent direct, without delay, to the Secretary-General, Dr. Depage, 75 Avenue Louise, Brussels.

Rugbiensis.—The plan adopted in similar instances by medical men wishing to show their disapproval of the conduct of a local medical charity is to boycott the institution and to advertise the fact as widely as may be. A mass meeting of neighbouring practitioners should be called to consider the question. Then, should it be decided to adopt extreme measures, resolutions could be brought forward resolving that no member of the medical profession should accept an appointment in the particular institution in question. This fact would of course require to be widely noticed in the medical journals together with a request for any medical man contemplating a vacancy' to write to the local secretary. There are certain circumstances under which the honour of the profession demands downright measures of this kind.

M.M.S. (Cardiff).—Thanks for the suggestion. We shall be happy to help so far as the publication of your most interesting case is concerned. The specimen would doubtless be welcomed by the curators of the Museum of the Royal College of Surgeons, London.

L.R.C.S.Edin.—You had better apply to the Secretary of the Association of Scottish Diplomates for full information. His address is 18a Hanover St., London, W. The gown of the Licentiates of the R.C.S. Edin., is of dark blue stuff with a sky blue yoke.

B.Sc.—(I) In the case of the fungi the emission of light may be more properly regarded not as a function of decay so much as one akin to respiration. The emission is not confined to the fertile part of the organism, but takes place throughout the whole mass. (ii) a useful work is "Plantés Remédies" by Dr. P. S. L. Lehamu, price 9 francs.

Dr. F. (Stirling).—The question of "accident" or "disease" is continually before the courts with regard to Workmen's Compensation. Judge Bacon recently refused to hold that caisson disease was an accident in the case of a man working on the railway, though anthrax has been more than once counted as such.

Dr. G. H.—The correct title of Nothnagel's work is *Topischen Diagnostik der Gehirn-krankheiten.*

A. D.—We hope to have space for your note on "Puerperal Convulsions" in our next.

Dr. Poynton's paper on "The Employment of Citrate of Sodium in Infant Feeding" is marked for early insertion.

Dr. P. L. is thanked for his communication which we hope to utilise in our next.

Student will find a new edition of the work referred to announced in our advertising columns by the publishers.

Mr. H. D.—We regret the reply must be in the negative.

Meetings of the Societies, Lectures, &c.

Wednesday, September 18th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. J. Clark: Clinique. (Surgical.)

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—3 p.m. Mr. Bidwell: Intestinal Surgery.

Thursday, September 14th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—5 p.m. Mr. Hutchinson: Clinique. (Surgical).

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—2 p.m. Dr. Arthur: Skiagraphy.

Friday, September 15th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. M. Yearsley: Clinique. (Ear.)

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—10 a.m. Dr. Shuter: Anæsthetics. 4.30 p.m. Mr. Bidwell: Intestinal Surgery.

Vacancies.

The University of Melbourne.—Professor of Anatomy. Salary £900 per annum. Applications to the Agent-General for Victoria, 142 Queen Victoria Street, London, E.C.

Waterford County and City Infirmary.—Superintendent of Nurses. Salary £60 per annum, with board, &c. Applications to Secretary (See Advt.)

Darlington Hospital and Dispensary.—House Surgeon. Salary £120 per annum, with board and lodging. Applications to the Secretaries, 49 Stanhope Road, Darlington.

Birmingham General Dispensary.—Resident Surgeon. Salary £150 per annum, and furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.

Brighton, Hove, and Preston Dispensary (Northern Branch).—House Surgeon. Salary £160 per annum, furnished rooms, coals, gas, and attendance. Application to C. Somers Clarke, Hon. Sec., 115 Queen's Road, Brighton.

City of Liverpool.—Fazakerley Hospital for Infectious Diseases.—Medical Superintendent. Salary £400 per annum, with house, coal, and lighting. Applications to the Chairman of the Port Sanitary and Hospitals Committee under cover, to the Town Clerk, Municipal Offices, Liverpool.

Appointments.

Drew, John, M.D.Glasg., Certifying Surgeons under the Factory and Workshop Act for the Stirling District of the county of Stirling.

Ellis, Francis H., B.A., M.B., B.C.Cantab., M.R.C.S.Eng., L.R.C.P. Lond., Assistant Resident Medical Officer at the London Open-air Sanatorium, Pinewood, Wokingham, Berks.

Greenwood, T. Parker, M.D., B.Sc., Assistant Medical Officer of the County Asylum, Radcliffe, Notts.

Kemp, Frederick W., M.B., B.Ch.Durh., M.R.C.S.Eng., L.R.C.P. Lond., Junior House Surgeon at the Radcliffe Infirmary, Oxford.

Norwood, William L., L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Bellanagh District of the county of Cavan.

Routley, E. W., M.D.Brux., D.P.H.Cantab., M.R.C.S.Eng., L.R.C.P. Lond., Medical Officer of Health of Aldershot, and Medical Superintendent of the Isolation Hospital, North Town, Aldershot.

Births.

Edleston.—On September 5th, at Ashenfell, Baslow, Derbyshire, the wife of R. Shafto C. Edleston, M.R.C.S., L.R.C.P.Lond., of a daughter.

Marriages.

Speirs—Roger.—On September 6th, at the Parish Church, Egglescliffe, Hugh Meredith Spiers, M.D., Diss, Norfolk, second son of W. R. Spiers, M.B., Haltwhistle, to Helen Mary Agnes, eldest daughter of Robert Roger, J.P., of Egglescliffe.

Deaths.

Bell.—On September 3rd., at 9, Sussex Square, Brighton, T. Vernon Bell, M.D.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, SEPTEMBER 20, 1905. No. 12.

Original Communications.

THE TREATMENT OF
GENERAL PERITONITIS. (a)

By DR. ANDREW J. McCOSH, M.D.

IN their treatment of general septic peritonitis, surgeons are not by any means agreed as to many important points. There is at present as much difference of opinion on this subject as was the case ten years ago. This prevails not only concerning the details of operation, but also concerning the general principles of treatment. In recent years this divergence has been in part caused by our better knowledge and appreciation of the ability of the peritoneum to absorb and destroy the poison generated by bacteria. We are now aware that a considerable amount of poison and exudate can be readily disposed of by this membrane. Hence has come a tendency to be less confident of the invariable necessity for operation, or at least to be less energetic and painstaking in the toilette of the infected peritoneal cavity.

There should, however, be no one rule of treatment. It should vary according to the etiology, duration, and virulence of the disease, and also according to the resisting power of the patient. The wisdom of the surgeon will be shown in the proper selection of the principle and methods of treatment. Certain hopeless cases will be encountered where euthanasia is the only treatment indicated. In other cases operation is demanded, and in yet others the surgeon may be at a loss to decide which plan will offer the best chance for recovery.

The etiology of the case influences the prognosis, as well as the means of treatment. The immediate shock which results from the escape of poisonous fluids into the peritoneal cavity through rupture or perforation of a viscus, does not now concern us, neither does the propriety of immediate operation for its relief. Peritonitis, however, rapidly follows. At first this may not be of a very virulent type, but it is continuously fed and aggravated by the poisonous outflow, until the leakage is stopped. On the other hand, the poison which escapes from a leaking vermiform appendix is more virulent, but its amount is smaller and its wider distribution may be blocked by adhesions of neighbouring organs. The rupture of a pyosalpinx is apt to cause a milder grade of peritonitis than that which follows the escape of intestinal contents. Leakage from the inflamed or gangrenous gall-bladder, if not blocked by adhesions, is apt to produce a severe grade of peritonitis. In the case of a perforation of a hollow viscus, where absence of adhesions permit of the outpouring of large amounts of toxic fluids, there is but one appropriate treatment. Immediate operation is demanded. As examples may be mentioned gastric, duodenal and typhoid perforations, or those due to a foreign body from the intestine or the gall-bladder. Similar treatment is indicated for peritonitis due to strangulation of intestines, whatever be the cause. In all these cases immediate and rapidly conducted operation for removal of the cause with appropriate treatment for the peritoneal inflammation, is indicated. The vast majority of cases, however, of general septic peritonitis are due to appendicitis, and it is especially to this form of the disease that the following remarks will apply.

The resistance of the patient has naturally a marked influence on the prognosis, as it should on the treatment. In this connection age is a factor of great importance. In a young boy or girl the most hopeless-looking case will not infrequently recover, and this in spite of the particular, method of, treatment. The elderly individual, especially if his liver, kidneys, and heart have been subjected to years of dissipation, will but rarely recover. My own methods of treatment are distinctly influenced by these considerations, and the larger my experience the more am I convinced of their reliability.

The prognosis will largely depend on the degree of septic intoxication present, whether this be due to the virulence or duration of the poison, or to the feeble resisting power of the patient. On this also should be mainly based our plan of treatment, and as has already been stated this should vary according to the conditions which we encounter. No one plan is suitable for all cases.

One of the most important and burning surgical problems of the day concerns the propriety of operation upon all (except moribund) cases of general septic peritonitis. Shall operation be the universal rule, or shall it be employed in selected cases only, or shall it be practically rejected ? These are the three most important questions for our discussion. It may be fairly stated that the majority of surgeons favour an affirmative answer to the first of these questions, and as a rule recommend immediate operation. A fair minority would perhaps agree to the second proposal and select according to their judgment certain cases for immediate operation and others for non-operation or at least delayed operation. A small minority, including, however, some able and experienced surgeons, would rather agree to the third proposal and reject immediate operation in practically all cases. It is mere waste of time to discuss the views of a few surgeons, who teach that these cases are practically hopeless whatever may be the treatment. For further elucidation it may be convenient to divide these cases into two categories.

1. Patients in desperate or moribund condition. The pulse is small and feeble, generally very rapid, 130-140, the face has a most distressed and anxious appearance, vomiting is almost constant. The abdomen is enormously distended and hard as a blown-up football, respiration is rapid, distressing, and shallow, the extremities are bluish, often there is a semi-gangrenous odour emanating from the patient's body. The mind, even in the most desperate of these cases, is often clear and the eyes bright. The prognosis in this class of patients is practically hopeless ; death will end their sufferings within twenty-four hours; operation is contra-indicated. It will but hasten the fatal result and is apt to bring discredit upon surgery.

(a) Paper read at the First Congress of the International Society of Surgery, Brussels, September 18-23, 1905.

2. The patients are critically ill but not moribund. The heart's action is feeble and generally very rapid, but the circulation is not yet hopelessly impaired. Vomiting is frequent and the abdomen is markedly distended and hard, but is not of the football variety. Respiration is less distressing, and the appearance of the patient is less critical. In this class of cases the majority of surgeons favour immediate operation. They claim that without operative interference such cases are almost invariably hopeless, while if operated upon, the percentage of recoveries will be from 30 per cent. to 60 per cent., or even 80 per cent. On the other hand, certain surgeons claim that the chances of recovery are better if the operation be postponed. These men maintain that their mortality since the practice of immediate operation has been abandoned has been distinctly reduced—indeed, as much as 50 per cent.

A few years ago I belonged to the first of these classes, and no one was more urgent than myself in advising immediate operation in practically all cases. In recent years I have been gradually questioning the advisability of this plan of procedure, and I now, especially since the teachings of Ochsner, class myself with those surgeons who would carefully choose operation for certain cases and reject it for others. Within the past few years I have often been agreeably surprised to see patients whom formerly I would have thought could only be saved by immediate operation, pass through the critical stage of the disease, when treated by absolute starvation, gastric lavage, &c. I have not, however, reached the position where I recommend non-operative treatment even in the majority of cases, but I firmly believe that we should carefully consider in every case whether operation will give the patient the best chance for recovery. Of course, in cases of perforated stomach or intestine or strangulated bowel, immediate operation is but rarely contra-indicated. When, however, the peritonitis is due to appendicitis, I am convinced that it is wiser not to follow any general rule of treatment, whether it be to operate or not to operate. The chances of recovery for elderly patients, especially if they have led dissipated lives, are, I believe, diminished if they be subjected to operation. The best treatment for these cases consists, I think, in absolute starvation, gastric lavage and small saline enemata, followed at a later date, if necessary, by operation for a localized suppurative peritonitis. On the other hand, youthful patients, I believe, should, as a rule, be subjected to immediate operation. In the class that are neither young nor elderly the surgeon must be guided in his treatment by the special features of each case. I must confess that at the present time I am often in doubt in this class of patients which plan of treatment to recommend.

I feel sure that these remarks concerning the doubtful propriety of operation in certain cases will be adversely criticised by many of you. It will be said, how is it possible for such patients to recover without operation, when we know that the intestines throughout are deeply injected, distended and paralysed, and where everywhere in the peritoneal cavity is found turbid serum or pus? I can only say that my experience in dozens of such cases has shown that without operation a fair proportion have fully passed through the critical stage of their peritonitis, to a condition where there remains but a localized abscess, in the midst of which lies a gangrenous appendix. At the end of a few days this is opened and the appendix removed by a comparatively simple operation. Sometimes, indeed, the case progresses to complete, or at least temporary, recovery, without even the formation of an abscess. Such is the remarkable power of the peritoneum for absorption and destruction of septic poison and inflammatory exudate. By some of you I feel sure it will be said that the diagnosis in these cases has been erroneous, and that the peritonitis has not been *general*. I cannot agree to this, for in a hospital experience of seventeen years I have operated on about 300 cases of general septic peritonitis, and certainly should be able to correctly diagnose this condition. I am willing to grant that in perhaps 10 per cent. or 15 per cent. of the cases my diagnosis may have been wrong, but certainly in the other 85 per cent. or 90 per cent. the experienced surgeon should not fail to rightly estimate the extent of the peritoneal sepsis and inflammation.

I do not wish to be understood as opposing operation, but simply wish to emphasize the fact that it is not always the best treatment. To illustrate my present treatment of general peritonitis, I may state that ten years ago I was in the habit of operating on perhaps 80 per cent. or 90 per cent. of all cases encountered. Now I operate only on about 50 per cent.

In these operations many different procedures have been employed. Some of these are discussed more fully later in this article. Many, such as the use of antiseptic solutions for irrigation, multiple incisions, post-operative irrigation, &c., have been abandoned as injurious.

The most important features of operation for general peritonitis are in my opinion (1) rapidity; (2) gentleness; (3) removal of the cause; (4) post-operative elevation of the trunk and head, with corresponding depression of the pelvis.

OPERATION.

Anæsthesia.—General anæsthesia as a rule is preferable to any method of local anæsthesia. There are exceptional cases where the latter may be indicated Chloroform is generally to be preferred to ether, though a mixture on an open mask is often the most advantageous.

Incision.—As a rule, when the cause is known, this should be made over the spot where lies the exciting lesion. As this is apt to be the appendix vermiformis, the incision will generally be made in the right inguinal region. In cases of doubt a median incision is best. Wherever situated, a length of 8-10 ctm. is generally sufficient. If not, the incision can be extended during the progress of the operation. An incision of from 12-20 ctm. does not seem to me to offer any advantages, and if recovery follows, is apt to result in discomfort to the patient.

As a rule, an intramuscular incision is not advisable, though in lax abdomens either the McBurney or Kammerer is sometimes sufficient. The incision along the outer edge of the right rectus muscle is generally the most convenient. When the peritoneal cavity is opened, fluid escapes. This may be under pressure, and squirt out with some force, but generally this means that the peritonitis is more or less localized. The character of the fluid may be turbid serum or thin pus. If the pus be thick, it is apt to mean a peritonitis which is not entirely general. The amount of fluid varies. There may be but little, or there may be a litre or more. The cause of the peritonitis is immediately sought and brought into view. At the same time it is determined whether or not the peritonitis be general. If general, irrigation through a tube is at once begun. Normal salt solution at a temperature of 110° is employed, through a hose of good size, and with considerable force. The rubber hose itself may be inserted, or there may be attached a long glass irrigating tube (in America, known as Chamberlain's tube) or a double-current glass tube, for ingress and egress of the fluid. The irrigation is begun in the flanks and systematically carried to different parts of the abdominal cavity, terminating with a thorough washing out of the pelvis.

This in itself consumes but little extra time, as it continues during the other steps of the operation, and terminates only with the insertion of the sutures. The hand of the operator, covered invariably by a rubber glove, helps, by gentle manipulation, the washing process. If the intestines have emerged from the abdominal cavity, they are protected by warm towels, and flooded with hot saline solution. Generally into the upper part of the small intestine there is injected through a large hypodermic needle 30 gm. of a saturated solution of magnesium sulphate, the puncture being afterwards closed by a Lembert suture. The exciting cause of the peritonitis has already been eliminated. If an appendix it has been removed, if perforation of an ulcer it has been sutured.

When the peritoneal contents have been replaced, nothing remains but the closure of the wound and drainage. This is effected by the employment of one or two drains of small diameter, the remainder of the wound being closed. One of these generally passes into the pelvis, and often another into the loin. This latter may emerge through a stab wound made posteriorly. My favourite drain is known in America as the "cigarette drain." It consists of a thin strip of sterile gauze around which is loosely wrapped a layer or two of thin rubber tissue. In place of the cigarette drain, especially if the pus be thick, a fenestrated rubber tube is sometimes employed. I never employ for purposes of drainage unprotected gauze strips or masses of packing. A strip of gauze carried through a glass tube into the pelvis is, however, occasionally used. For the emergence of these drains comfortable spaces are left in the wound unsutured, or the sutures may be inserted for future use, but left untied.

Often while the operation is in progress, an intravenous saline infusion is given by an assistant. The smallest possible amount of anæsthetic is administered. It is the operator's endeavour to complete the operation as rapidly as possible, and as a rule the patient is not on the table longer than twenty minutes. For the reduction of the tympanites, I have often given hypodermically, physostigmine salicylate 0.002 gm. I am very sceptical, however, as to the efficacy of this drug. A small hypodermic injection of morphine is usually administered at the close of the operation.

The treatment of these patients *after* operation is of considerable importance. It is not, of course, necessary to dwell on the means of stimulation, such as enemata, hypodermoclysis, venous infusions, &c. The post-operative posture of the patient, however, is, in my opinion, of the greatest importance. The head of the bed is elevated 40-50 ctm., so that the drainage current will be toward the pelvis. This, in America, is known as Fowler's position. It is maintained for about a week. The thighs are generally flexed over one or two pillows. This adds to the patient's comfort, indeed, the posture, whereby the chest and head are elevated, is usually pleasing to the patient. Starvation is absolute until abdominal distension is diminished by normal passages of flatus, and until vomiting ceases. Generally at least twenty-four hours elapse before anything except water in small quantities is allowed by the mouth. Saline enemata, small in amount, 250 gm., are regularly administered, and sometimes nutritive enemata are advisable. Gastric lavage is given often before the patient leaves the operating table, and is often continued at intervals until vomiting ceases, and abdominal distension diminishes.

It not only gives relief, but is most beneficial in its action, by removal of pressure from heart and lungs, and by encouragement of the intestines to resume their normal peristaltic action. Drainage remains as established, for 36 or 48 hours, and then its removal is begun cautiously and gradually. The drains being covered by the smooth and slippery tissue can be extracted without pain and without disturbance of the surrounding intestinal coils.

Having thus briefly outlined my general plan of procedure, it will not be amiss to dwell more particularly on some of the details of the operation, and to discuss them in connection with other methods practised often with equal success by other surgeons.

Rapidity of operation.—This seems to me one of the most important points. The duration of the operation should be as brief as possible. It should be completed in less than thirty minutes; indeed, fifteen or twenty minutes should generally be sufficient. To accomplish this result all details should be carefully arranged before anæsthesia is begun. Assistants and nurses should be fully instructed as to their duties. Complete infusion apparatus should be ready for immediate use. If the surgeon feels that the operation will consume an hour or more, I honestly believe that its omission will offer the patient a better chance for recovery.

Incision.—As already stated, an incision directly over the exciting lesion seems generally advisable. Some surgeons, however, feel that it is wiser to make the primary incision at some distant point, so that in case the peritonitis be not general, the unaffected area may be walled off by gauze, before the septic area is exposed by the second incision. Perhaps in certain cases, where there is considerable doubt as to existing conditions, this may be advisable, but it seems to me unnecessary, as a general rule, to resort to a procedure which adds somewhat, even if little, to the severity of the operation.

Methods of cleansing.—Perfect cleansing is, of course, impossible. The imperfect cleansing, however, which is accomplished in more ways than one, is often sufficient to tilt the scale towards recovery. Whatever method be employed, the avoidance of mechanical or chemical irritation of the lining cells of the peritoneum is of the greatest importance. Injury or irritation of these cells deprives the patient of just so much power to absorb and nullify the virulence of the poison, and exposes new areas for septic absorption. For this reason, I have for some time employed only normal saline solution. Chemical irritants, such a boric acid, Thiersch's mercuric bi-chloride, peroxide of hydrogen solutions, I have abandoned as deleterious. The saline solution is also useful as a stimulant, for a considerable amount is absorbed into the blood-vessels during the progress of the operation. Mechanical irritation, such as must result from sponging or rubbing the peritoneal surfaces with gauze, seems to me also to be injurious.

Drainage.—Concerning this detail so much difference of opinion and practice exists, that I fancy many divergent views will be forcibly enunciated at this Congress. At the one extreme, entire absence of drainage will probably be advocated; at the other, multiple and bulky drainage. As stated, my own practice limits drainage, as a rule, to one or two small drains, called in America "cigarette drains," which consist of a narrow strip of sterile gauze around which is wrapped thin rubber tissue. The thickness of the drain is usually not much greater than the ordinary lead-pencil. The rubber tissue employed is very thin, and is wrapped loosely around the gauze, which should not project beyond it more than 1 ctm.

The advantages of such a drain over strips of uncovered gauze are very great. As intestinal coils cannot adhere to the smooth rubber surface, any tendency to obstruction is obviated, drainage is more effectual and removal is painless and does not disturb or displace the surrounding intestines. As already stated, if the pus be thick, with the probability that this quality will continue for some days, a fenestrated rubber tube of the same size is preferable. Tamponades of gauze seem to me to be disadvantageous. They are apt to interfere with the proper intestinal peristalsis, if, indeed, they do not cause obstruction, and while protecting any special septic area, interfere with general drainage. An exception, however, is made, should there be failure for one reason or another, to remove the cause of the peritonitis. This is then shut off by gauze packing, so that it will not continue to poison the general peritoneal cavity. In operations for general peritonitis, however, this condition can but rarely exist. When, however, there is a suppurative peritonitis which has not yet become general, and where the patient is profoundly septic, the simple opening of the abscess with tamponade of the cavity without attempt to remove the appendix is unquestionably at times a life-saving procedure. Multiple drainage openings, with multiple drains, I am not inclined to favour, unless the peritonitis be of that variety where numerous distinct collections of thick pus are found at different points in the abdominal cavity. A tube into each of these pockets may then be of advantage. Otherwise I believe one, or at least two, drainage exits are as beneficial as half a dozen. I am opposed to post-operative irrigation. This, in past years, I have tried in various ways, but long since have entirely abandoned. The entire omission of peritoneal drainage has recently been strongly advocated by a few surgeons, and their experience, while not large, has certainly been sufficiently favourable to demand consideration. I believe, however, as a routine procedure, the absence of drainage is a mistake. Many a case will progress satisfactorily without drainage, but in a long series of cases I believe that the surgeon who employs some slight egress for poisonous secretions will have better results than he who closes the peritoneal cavity. I would, however, prefer entire absence of drainage to that which is attempted by means of large masses of gauze. To this I have always been opposed.

Evisceration of Intestines.—This should generally be avoided. In former years, I often deliberately encouraged the intestines to emerge from the abdominal cavity, in order that the cleansing process might be more thorough. I have never seen any great amount of shock result from this procedure, but I invariably used the utmost gentleness in my manipulation and endeavoured to protect the emerged coils by smooth towels wet with hot salt solution. At times, however, I found the replacement of the intestines attended with considerable difficulty, and as no distinct advantage seemed to result from the evisceration, I have in recent years tried to avoid any intestinal protrusion.

Removal of lymph.—Often, especially around the original lesion, there will be seen masses of fibrin, and patches and flakes of the same material may be found at different points adherent to the intestines. Should these be removed? If very loose or hanging by a thin attachment, they should, I think, be removed. If, however, the patches be quite adherent to the intestines, it seems to me better practice to leave them undisturbed They may be infectious, but it is wiser to take the chances of a small localized septic process rather than by their removal to expose new areas for the absorption of the sepsis.

Enterotomy and enterostomy.—If the small intestine is found to be enormously distended, and especially if during the irrigation it has partially escaped from the abdominal cavity, I am inclined to believe that an incision in its wall, and the "milking out" of some of its contents, is in some cases a beneficial measure. Some years ago, I showed that a mere opening will not empty the intestine for a distance longer than perhaps 50 ctm., and to effect a substantial evacuation, even of gas, a so-called milking process must be practised. This must, however, be carried out with the utmost gentleness by the gloved fingers. The opening, in my opinion, should be at once closed by suture. The usual protection of the peritoneal cavity is, of course, employed.

A temporary enterostomy is not, in my opinion, often of benefit; indeed, I think it exerts a rather deleterious influence. It will not lessen the sepsis, and if the intestines mean to recover their peristaltic action, this will be accomplished without the aid of an artificial anus. Its establishment adds slightly to the duration of the operation, and in my experience, after the expiration of a few days, by reason of septic complications and interference with nutrition, it has been distinctly prejudicial to the patient. Its early closure is, of course, designed, but this cannot usually be attempted until a week or two has elapsed, as the patient before this time will not be in a condition to endure a secondary operation of such difficulty. My experience with this procedure, has, I grant, not been great, and I also grant that in some cases it may be of some advantage, but as a general practice I am inclined to consider it with disfavour. The Greenough tube I have not employed, but I should judge that in certain cases it might be beneficial.

Injection of magnesia sulphate into the small intestine, by means of a hypodermic needle, formerly seemed to me a measure of considerable value. Though I still employ it, I am less enthusiastic as to its value Some surgeons, however, regard it with favour, and I am still inclined to believe that it is often beneficial. If the source of the peritonitis has not been removed, it, of course, should never be employed.

Post-operative position.—As already stated, I firmly believe that the elevation of the upper part of the body, with the depression of its lower part so that the current of the abdominal drainage is downwards toward the pelvis, is of the greatest value. The head of the bed should be elevated about 50 ctm. It is known that the pelvic peritoneum is more tolerant to poison than that of the upper abdomen, and the employment of this posture enables the patient to make use of this property, as well as to take advantage of the force of gravity. Equally prejudicial, in my opinion, is the reverse position where the pelvis is elevated and the chest and head depressed.

CONCLUSIONS.

1. No one plan of treatment is applicable for all cases.
2. The majority of cases are best treated by operation, but there are also many cases where operation diminishes the chances for recovery.
3. Undoubted cases of general peritonitis recover without operation.
4. Rapidity, gentleness, and removal of the cause are the most important features of the successful operation.
5. Irrigation with saline solution is generally recommended. All chemicals and mechanical irritants are to be avoided.
6. Drainage should be provided, but the drains should be smooth, non-adhesive, and of small diameter. The cigarette drain is preferred.
7. Enterostomy is not advocated.
8. Gauze packing is injurious.
9. Fowler's position after operation is most advantageous.

NOTES ON THE
FUNCTIONAL EXAMINATION OF THE EAR BY MEANS OF THE VOICE.

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THERE are several difficulties which prevent the regular use of the human voice in the testing of the hearing of aural patients. One of the least, perhaps—but certainly one—is the slowness with which suitable words suggest themselves to the surgeon when he has his patient sitting in a quiet room, prepared to repeat the words he hears.

It is not satisfactory to propose as tests the first words which occur to the mind, because some common words are easily recognised, whilst others are recognised only with difficulty. The different vowels and consonants of which words are made up vary so much in their perceptibility to the organ of hearing, that unless some arrangement be observed, it is not possible to obtain any clear idea of the hearing in the case under examination, and equally impossible to tabulate and compare the results arrived at.

For example, a relatively deaf man may hear the word "sash" quite well, while another man, not so deaf in reality, may fail to hear the word "rule" (both men being tested at the same distance from the examiner, and under the same conditions); for "sash" is one of the easiest words to recognise, while "rule" is one of the most difficult.

Clearly, then, it is necessary for the examiner to have some idea of the relative sound-value of the words he is proposing as tests, and to bring those words forward in some proper order.

Possibly some of your junior readers may have experienced, as I have, the difficulty of calling to mind suitable test-words in sufficient number while the patient is waiting. If any have, perhaps they will look kindly upon a short list of words which I have prepared for my own use, and which I propose setting down here.

I have drawn up the list on the basis of the teaching in Professor Politzer's clinic in Vienna, where, under the superintendence of the professor and his assistant, Dr. Gustav Alexander, both in-patients and out-patients are regularly tested by means of the human voice; and the watch, which is so commonly used in this country, is discarded so far as air-conduction is concerned.

Sound-Values of Different Letters.

A.—Vowels.

1. Of the vowels, " a " (the German *a*,—long, as in English *alms*,—or shorter) has the greatest sound-value, being heard at the greatest distance of all, and always, if heard at all, being heard as *a*.

The other vowels follow in this order, the list ending with the vowel of least sound-value:—

2. German " i " (as in English *field*—long, or *milk*—short).

3. German " e " (as in English *share, shell, they,* &c.).

4. German " o " (as in English *stone*, or *off*).

5. German " u " (as in English *rule*, or *full*).

It is to be noticed, too, that as one approaches the limit, with the later of these vowels there are often mistakes made, even when the listener thinks he hears.

B.—Consonants.

Of the consonants, those having the " s " sounds are the best heard, including not only the sound of " s " in *sun*, but also that of " z " in *zeal*, and that of " sh " in *shell*. The consonants heard with the greatest difficulty are " r," " m," " n," " l." The remaining consonants occupy different positions intermediate between these two extremes.

If, then, a surgeon wishes to find the utmost limit of his patient's power of hearing, he will propose to him words made up of these hardly-heard vowels and consonants; for example, such words as *moan* or *own*. And he can find the limit in the other direction by uttering only words composed of " s's " and " a's," such as *sash, ass,* &c.

Midway between these extremes are what one may call " middle " or " mixed " words, in which the other vowels and consonants figure—" e," and " b," " k," " t," &c. These mixed words are perhaps the best adapted for trying first with average patients; one of the other groups being employed if it is necessary to make the test more severe, or less, as the case may be.

Classification of Words.

I have arranged the test-words in three main groups:

I. Those most easily heard.

II. Those heard with the greatest difficulty.

III. Those intermediate in difficulty—mixed words.

I shall enlarge upon them in this order for convenience of description, although I have recommended above the use of the words belonging to Group III. first, Group I. or Group II. being used next, according as the patient's hearing is comparatively bad or good.

I. The first group of words contains—

(*a*) Those most easily heard, on account of their " s " and " a " sounds.

(*b*) Some a little less easily heard, having the " s " sound and the " i " (German " i ") sound.

(*c*) Others a little more difficult to hear, having still the " s " sound, but, as vowel, the " e " (German " e ") sound.

It will be observed that every word in this Group I. has only the easy " s " sound in its consonants; and that—

Those in (*a*) have the vowel " a " sound alone.

Those in (*b*) have the vowel " i " sound, combined sometimes with the " a " sound in a separate syllable.

Those in (*c*) have the vowel " e " sound, combined sometimes with one of the two easier vowel-sounds above.

Group I.—(*a*) Ash – ass – sash – Shah.

(*b*) Ashes – ashy – easy – sea – she.

(*c*) Ace – Asia – assay – assess – chase – chess – essay – etch – say.

II. All the words in the second group contain the most difficult of the vowel-sounds, namely, " u," and one or more of the difficult consonants, " m," " n," " l," " r ":—Loo – loom – loon – lure – moo – moon – moor – noon – room – rue – rule – rumour – rune.

III. In the third group are the intermediate (middle or mixed) words, having one or more of the consonants, " b," " p," " k," " c " (hard " c "), " t," " d "; and also one of the vowel-sounds of medium difficulty. These words I have arranged further into three classes, each class containing words a little more difficult of recognition than those in the one preceding it:—

(*a*) Words having the medium vowel-sound " e ";

(*b*) Words having the slightly easier vowel-sound " i ";

(*c*) Words having the slightly harder vowel-sound " o."

(*a*) Ache – aid – ape – ate – bade – bait – bake – bay – cade – cake – cape – Kate – paid – pate – take – tape – Tate.

(*b*) Bead – beak – beat – bee – bib – bid – bit – Dick – did – dip – ditty – eat – keep – key – kid – kit – peat – pick – pip – pique – pit – tea – teak – teat – teed – tip – tit – Tydd.

(*c*) Boat – bob – bode – coat – cob – cock – cod – code – coke – cope – cot – dock – dot – dote – pock – pod – poke – pop – pope – pot – toad – tod – toe – top – tope – toque – tot.

It is obvious that mixed words are the most plentiful. And they are the most important, for, of course, they approach most nearly in their sound-values to ordinary speech, which is what the patient probably most wishes to hear.

Other mixed words of considerable value are numerals. But simple words, such as appear in this list, have the great advantage that the whole word must be heard before the patient can repeat it; in the case of polysyllabic words it is often possible to recognise, in its entirety, a word of which various letters have been missed. And, further, the ability to repeat a long word depends in part upon the strength of the memory, and such a word is not therefore a pure test of hearing.

The Examination in Practice.

A few notes on the actual examination of the hearing by means of the human voice, as practised by Professor Politzer and his assistants, may be acceptable to some of the junior surgeons who are desirous of employing the method.

The patient sits or stands in a quiet room, with one ear, usually the right to begin with, turned to the surgeon. The other ear is closed by the insertion of a finger-tip, which is more efficient if it is first dipped in water. So placed, the patient cannot see the examiner's mouth as he pronounces the test-words, and so he gets no help in the recognition of the words from any ability in lip-reading he may possess; and the stopped ear is excluded from examination. Excluded, that is, as far as possible—for one cannot exclude one ear absolutely. The surgeon may test himself as to this. If, having normal hearing on both sides, he close both ears as firmly as possible, he can yet hear conversation at about a yard's distance. The explanation of this is that sounds are conducted, not only from the external meatus to the internal ear, but also from the nose by means of the Eustachian tube to the middle ear and thence to the internal ear, and also from one internal ear to the other across the skull. This impossibility of excluding one ear absolutely has to be borne in mind, especially in the examination of patients who have one very good ear and one very deaf one. In such cases the test is more satisfactory if it is conducted through the speaking-tube, for this excludes the second ear from the examination more completely than when the moistened finger is used alone.

These preliminaries having been arranged, the patient is directed to repeat aloud, and at once, the words which he hears uttered.

First, then, the surgeon may test with his ordinary conversational voice (C. V.). Beginning at a distance of, say, two yards, and addressing himself directly to the ear under examination, he pronounces, distinctly, of course, one of the " mixed " words of Group III. If the patient hears it, and repeats it, the surgeon goes farther away, and pronounces another such word, and so continues, moving gradually farther and farther away, until he reaches a point at which the patient fails to repeat correctly the word uttered. At this distance, one or two words may be tried, so as to make quite sure of the patient's helplessness, but it is better not to repeat any one word, which has not been recognised, more than once, but rather to change to another.

If the room in which the examination is being conducted is not large enough to permit of the limit's being reached in this way, the surgeon may turn his back to the patient, and, standing a yard from the further wall, may address the words to the wall. This is called the "half-turn." If still the patient hears, *he* also may be turned round, so that the ear under examination is turned away from the surgeon, and directed to the wall, from which it is one yard distant; and then, standing himself in the "half-turn" position, the surgeon may pronounce his test-words again. This is called the "full-turn."

The distances under these circumstances are reckoned thus:—The distance of the voice in the "half-turn" position is equal to the full distance of the patient from the surgeon, plus one-third of the full distance. For example, if the room is eleven yards long, and the patient sits one yard from the wall, and the surgeon stands one yard from the opposite wall, nine yards is the full distance between them. Then the distance in the "half-turn" is reckoned as nine yards, plus a third of nine yards (nine plus three), or twelve yards. In a similar manner, the distance in the "full-turn" position is reckoned as the full distance, plus *two*-thirds of the full distance; in this example, therefore, it is nine plus six, or fifteen yards.

Of course, one need not press the examination with the mixed words to this extent; but, having found that they are heard at the full length of the room, the examiner may have recourse to the difficult words of Group II.

On the other hand, if the mixed words are not heard at the two yards' distance at which the examination began, one may at once make use of the easy words of Group I. Or he may approach nearer to the patient than two yards, still using the mixed words, until he finds a position from which they can be heard.

The right ear having been thus tested, the left is examined in exactly the same way.

Next, both ears should be tested together, the patient thus being in his natural and everyday condition. This is of more practical than scientific importance. For it sometimes happens that a patient complains of subjective noises, and yet only hears them when both ears are open; if, then, one ear be closed, he may hear better, for the noises are not present to distract him. The binaural examination is best done by letting the patient (standing or sitting) face the surgeon, and look at his feet while being tested.

After the conversational voice, the whispering voice (W. V.) should be employed. Properly speaking, whispering is "articulation without voice," so that exact whispering is not really audible. In practice, however, "very little" voice is used as the whispering voice.

This part of the examination is conducted just as that with the conversational voice was—first the right ear, second the left ear, and last both ears together.

It is not possible to state exactly the normal hearing-distance of the voice, either conversational or whispering, for it depends largely upon the place and conditions of examination. But the average distance of the conversational voice is said to be normally about fifty-four yards; and that of the whispering voice about twenty-five yards.

If the patient hears so badly that even the easy words of Group I. are not perceived, the surgeon must try more violent means of irritating the aural apparatus.

3. He may try a stronger or "over-loud" voice, articulating with forced expiration. If this is not heard, he must use—

4. Consonants or vowels alone; or, failing their perception,

5. Strong noises and shouts.

This examination being completed, and before one takes up the tuning-forks, Politzerisation or catheterisation should be practised. Then the hearing should be tested again as before.

If the distance at which the words are now heard be distinctly and clearly increased, as from one yard to three, or twenty yards to fifty, it is right to hold that improvement has occurred. An increase of fifty yards to sixty, however, would not justify one in thinking that there was improvement. The surgeon must be on his guard, also, against thinking he has improved the hearing in a given case, when the apparent improvement is due to the patient's having become accustomed to his voice, and so recognising the words more easily. It is, by the way, to the conversational voice that improvement is usually most marked.

TREATMENT OF URINARY HÆMORRHAGE.

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PROFESSOR GUYON, in his (*a*) lecture on hæmaturia, says:—"I have already called attention to the fact that all parts of the urinary apparatus may become the starting-point of severe hæmorrhage. The prostate gland is an organ which inclines to bleeding, a fact which is proven by accidental injuries which occur while catheterising or operating upon this gland. Many times hæmorrhages of the gravest kind occur, even fatal ones. Injuries are sometimes produced even with soft instruments, by 'false passages,' or simple erosions such as a soft catheter might produce, and are often followed by such abundant hæmorrhage as to be out of proportion to the insignificant cause."

It is well known that these hæmorrhages can at times only be conquered by surgical means. We nevertheless possess a small number of medicinal preparations which were recommended by Guyon and his followers such as argent, nitrate chloride of iron and tannin for local use, and ergot for internal medication.

The corroding properties of the former medicines have already been pointed out. Quinine acts very slowly and ergotine, although acting promptly as, Desnos (*b*) says, its action has to be watched, as it increases the contractions of the bladder and consequently aggravates the congestion and the hæmorrhage. We therefore hail gratefully the fact that *muriate of cotarnine*, which is known by the name of "Stypticin," has proved itself a valuable hæmostatic for urinary hæmorrhage. Good results have been obtained, especially with this remedy as a local hæmostatic, and we recommend it as such. It is a notable fact that in comparison with chloride of iron (*c*), it does not act corrosively. I cannot, however, substantiate this statement absolutely in this positive form, as I have had complaints from several patients that they felt an intense and disagreeable burning sensation in the urethra after local application, which made itself felt especially while urinating. This irritation is likely to have been produced by dissociated chlorine ions.

This point induced me to test a number of cotarnine preparations, manufactured by the firm of Knoll and Co., of Ludwigshafen and London, in order to test their hæmostatic qualities.

The *Phthalate of cotarnine* proved itself the best of all. During the course of these experiments I found that phthalic acid salts (we took phthalate of ammonia) showed hæmostatic and antiphlogistic action by apparently contracting the capillaries. In superficial inflammations it can be observed that a 2 per cent. to 5 per cent. solution will pale the inflamed red spots and decrease the pain. For extensive eczema, a 1 per cent. to 2 per cent. solution was found best, while a 5 per cent. solution was used for small furuncles. In connection with its application for furuncles, it should be stated expressly that the effect is only obtained on the surface, and that in extensive furunculosis a paling of the superficial inflammation may be observed, but the deeper infiltration does not subside. This proves that this remedy is indicated only for smaller furuncles or superficial inflammation of the skin. Without doubt it possesses an *antiphlogistic* and *astringent* action.

Much more important and interesting is the fact that phthalic acid possesses also a *local hæmostatic action.* We have tried neutral phthalate of ammonia—a compound in which the pure effect of the acid is excluded—for a number of capillary hæmorrhages, such as occur in daily practice, also for furuncles, after the pus had been squeezed out, for small cuts, &c., and we have always had a splendid hæmostatic effect. In order to obtain this effect it is, however, necessary to employ stronger solutions of at least 10 per cent. to 30 per cent. In severe hæmorrhages, the powder may be used directly, which does not induce coagulation or formation of a crust, an absolute proof that the hæmostasis is not induced by crust formation such as is effected by the use of nitrate of silver or chloride of iron.

A dentist lately was induced to try the phthalate of ammonia, and found that the hæmorrhage after extraction absolutely stopped in two minutes after the use of the remedy. He furthermore endorsed our own observation. From these observations, we deduct that a union of a cotarnine base possessing a styptic action with an acid which also should have hæmostatic qualities and at the same time be antiphlogistic and non-corroding, must be *a priori* a good combination.

Experiments which included other combinations resulted in the conclusion that *Phthalate of cotarnine*, or, as it is now called, "*Styptol,*" is, indeed, an excellent hæmostatic. It is a yellowish powder of bitter taste, and easily soluble in water. Its formula is as follows:—$C_6H_4\ (CO_2H)_2$—$(C_{12}H_{13}NO_3)_2$ (1 mol. phthalic acid, 2 mol. of cotarnine).

Its solution, unlike stypticin, has a slightly alkaline reaction, turning red litmus paper blue; while the latter shows a weak acid reaction upon litmus paper. Both preparations, however, react neutrally to phenol phthalein. This slight alkaline reaction must be counted an advantage, as it is applied to the mucous membrane of the urethra, which tolerates this weak alkaline solution better than neutral or weak acid ones. Even common salt in strong solution, 0.75 per cent., acts as an irritant, a fact which is well known.

We have further made the following experiments for comparison:—The injection of a 2 per cent. solution of muriate of cotarnine or stypticin, by means of a gonorrhœal syringe, into the urethra produces an intense burning sensation which increases during micturition and continues for some time. On the other hand, the injection of a 2 per cent. solution of *phthalate of cotarnine* or *styptol* scarcely induces more than a slight burning at the start, which subsides immediately. Micturition after this injection is painless. The difference will be specially marked if the injections are made into the posterior part of the urethra. E. Korzl has lately reported washing out the bladder with a 5 per cent. to 10 per cent. or even 20 per cent. solution of stypticin, but we have to warn against the use of such strong solutions most emphatically, as they are dangerous according to our experience on account of the danger of intoxication. Our observations with *styptol* cover a period of over two and a half years, and we have tested it during this time internally as well as locally for different kinds of hæmorrhages of the urinary organs. At first we gave a dose of 0.1 grm. internally, in the form of powder, later, however, exclusively in tablet form of 0.05 grm., four to six a day on an average.

The following cases, briefly described, will serve to show the action of this drug:—

I. *Hæmorrhage in Gonorrhœal Urethritis and Cystitis.*—O. Sch., æt. 22, treated since October 10th, 1902, for acute anterior and posterior gonorrhœa. *October 13th,* 1902: Patient has very profuse, bloody discharge; marked œdema præputii; lymphangitis penis; urine No. I. and II., strongly coloured with blood. *Treatment: Stypticin,* one tablet six times daily; introduction of gelatine suppositories into urethra containing each 0.05 grm. *stypticin. October 15th:* Hæmorrhage continues without improvement; *styptol* tried instead of stypticin, 0.1 grm. four times a day. *October 16th:* Hæmorrhage very much less. *17th:* Only second urine slightly coloured with blood; styptol given three times a day, in doses of 0.01 grm. *18th:* Urine I. and II. still cloudy, but without any blood. The hæmorrhage did not appear again.

II. L.N., æt. 36, chronic prostatitis for eight years, and chronic gonorrhœa. *October 23rd,* 1902: Acute cystitis in consequence of having caught cold; had excessive hæmorrhage after micturition. *Treatment: Styptol,* 0.01 grm. four times daily. *October 24th:* Hæmorrhage less. *25th:* Hæmorrhage has stopped; urine still cloudy; styptol three times daily, 0.01 grm. with fol. uvæ ursi as decoction. *31st:* Urine clear again, with filaments. Cured.

III. A.H., æt. 35. Acute gonorrhœa since December 29th, 1902, treated. *February 7th,* 1903*: Acute* epididymitis right side; urine bloody. *Treatment:* Styptol three times a day, 0.1 grm. *November 11th,* 1903: Hæmorrhage has disappeared; only the first urine cloudy. *Result:* Cured.

IV. W. R., æt. 24. For three weeks, acute gonorrhœa; was treated by Omach. *April 24th,* 1903: Very profuse discharge; severe œdema of prepuce; very painful erections; profuse hæmorrhage after micturition; 40 grm. of blood. *Treatment:* Styptol tablets of 0.05 grms; about six daily. *May 2nd*: Œdema nearly gone, hæmorrhage less; suppositories with morphia instead of styptol, ergotine; no improvement. *May 5th:* Styptol only in powders of 0.1 grm.; hæmorrhage less. *8th:* Only slight hæmorrhage; styptol three times a day of 0.1 grm. *May 6th:* Hæmorrhage has disappeared entirely. I could add many other cases of this kind with similarly satisfactory results.

Hæmorrhage in Cases of Hypertrophy of the Prostate Gland.—S., æt. 51. Has had trouble during micturition for six months. Patient had been handed over to us by the attending physician, on account of marked symptons of retention combined with extensive hæmaturia. *August 20th,* 1903: On examination, prostate gland hard, size of a small apple; enlargement diffused; micturition very difficult; urine with coagulated blood. *Treatment:* Decoct. fol. uvæ ursi. Styptol tablets every two hours, 0.05 grm. *21st:* Urine slightly cloudy, containing bacteria coli in culture; 50 grms. of uric acid residue, but entirely free from blood. Washing out with 0.1 per cent. sol. argent nit. *24th:* Urine still slightly cloudy, but without blood. Hæmorrhage has not returned as reported by fellow physician.

Similarly satisfactory results followed treatment of cases of hæmorrhage from tubercular cystitis.

References.

(*a*) "Die Krankheiten der Harnwege." Clinical lectures from "Hopital Necker." Translated by O. Kraus and O. Zuckerkandl. Vienna.

(*b*) "Traité élémentaire des Maladies des voies urinaires," Paris.

(*c*) Uber Stypticin.—I. Stypticin as a local Hæmostatic "Monatschefte f. Pract. Dermatologie," Vol. 34, p. 161.

We understand that the Colonial Office has recently addressed a communication to the Liverpool Tropical School, asking for the services of Professor Boyce, the director of that institution, in order that he may proceed to the West Indies to conduct an inquiry into the sanitation and health conditions of those colonies.

THE IRISH MEDICAL ASSOCIATION: ITS RE-ORGANISATION AND ITS FUTURE. (*a*)

By R. J. KINKEAD, M.D.,
Professor of Midwifery, Queen's College, Galway; Ex-President of the Irish Medical Association; Vice-President for Connaught.

I.

The necessity for the reconstruction of the management of the Irish Medical Association, and the lines upon which the reconstruction should be carried out, are demonstrated by the failure of the existing machinery to carry into effect the objects for which the Association is established.

The existing organisation of the Association is, general meeting, office-bearers, council, and committee of council.

The Irish Medical Association, being a limited liability company, registered under the Joint Stock Companies Acts, must hold an annual general meeting; other general meetings may be held under conditions provided by the Articles of Association.

The Association cannot be said to suffer from a dearth of officers: with a president, four vice-presidents, an honorary treasurer, an honorary secretary, a deputy chairman, an honorary secretary of the council, and a secretary.

The council is compounded of twelve ex-officio members, thirty-two county councillors, and thirty-two general councillors; it meets quarterly.

The committee of council consists of the president, the honorary treasurer and the honorary secretary of the Association, the deputy chairman, and the honorary secretary of the council, together with five of its members selected by the council at its first meeting; it is bound to meet at least once each month, except in August and September.

The general meeting has been stripped of all power except voting, passing resolutions, and dining.

Save as a debating society and to loom large as the Irish Medical Association, there is no use for the huge irresponsible council; it cannot keep in touch with the business, and is unable to carry out the objects of the Association; the intervals between the meetings are too long, and the attendance varies, so that practically there is a new council at each meeting; it is not responsible to the general meeting, five of the ex-officios are not appointed by, and need not be, members of the Association, the thirty-two county councillors are responsible solely to the gentlemen who nominated them—possibly themselves—or in cases of contests to the county members who vote for them, only the thirty-two general councillors are elected by the Association. It is not subject to the control of the general meeting; it is not bound to obey its mandates, or carry out its resolutions; nor has power been reserved to dissolve an inefficient or insubordinate council.

"The administration of the Association" is vested in the council; therefore it debates and declares the policy of, and acts as if it were, the Association.

The committee of council, being semi-official has discovered that important business must be done—not necessarily well done—in a hurry, and therefore that at least fortnightly meetings must be held. As country practitioners cannot possibly attend in Dublin every fortnight, the committee of council has been, and must, so long as one exists, be composed exclusively of Dublin members, latterly mainly of the medical officers of the two Dublin unions.

I am glad of this opportunity of testifying to the debt of gratitude due by the Association to Dublin members, most of them not connected with the Poor-law service, who freely gave their time and money to its services from a sense of duty and love of their profession; were it not for them the Irish Medical Association would long since have ceased to exist; it is not, however, in the interests of the Association or the profession that the power and control of the Irish Medical Association should be in the hands of men of one locality.

The committee of council is the real governing body, it is the power behind the throne; it alone is conversant with the details of business, and keeps in touch with current affairs; nominally it is bound to carry out the instructions of the council, but the council can only instruct as the committee advises; it has absolute power over the funds of the Association, if a question of expenditure arises, it is within its rights to reply *sic volo sic jubeo*; it has not hesitated to act autocratically. Without the sanction or knowledge of general meeting or council, it authorised the publication of a directory which cost the Association some £70 at a time when law costs, *estimated at* £645, had been incurred, and it overruled decisions of the council and nearly rent asunder the Association over the Evatt report.

The rule of this omnipotent committee of ten has been as unfortunate for the Irish Medical Association as that of its prototype the council of ten was for Venice.

Whether regarded from the financial point of view—the report of the council for last year shows an income for 1905, including a cash balance from 1904. of £1,002, and on the other side of the account debts amounting to £750, and 113 members in arrears—or from that of membership, the working of the present cumbrous system of management cannot be characterised as successful, not from default of the men, but from the inherent imperfection of the machinery.

"The objects for which the Association is established" are set forth in the Memorandum of Association. The chief one, to which all the others are subsidiary, is, "To unite the members of the medical profession in Ireland so as to form a body, competent to exercise influence in sanitary and medical affairs for the public benefit, and to protect and promote the interests of the medical profession."

In 1885 the Irish Medical Association numbered 586 members; in 1890, 477; in 1895, 561; in 1900, 598; and in 1905, 881. At the beginning of the present year there were 2,558 resident practitioners in Ireland, of whom 935 were in the Poor-law service. That in 20 years only one-third of the medical practitioners of Ireland and something over a half of the Poor-law medical officers have joined the Irish Medical Association fully bears out the statement in the report of the

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(*a*) Being the first of series of articles specially communicated to the columns of the Medical Press and Circular by prominent members of the Irish Medical Association.

organisation committee, "It is essential that the central machinery should be recast so as to make it more efficient for the transaction of business, and enable the Association to win the confidence of the profession, as a body capable of carrying out the objects for which it has been established and protecting and promoting the interests of practitioners and of the profession."

The power of the Association resides *de jure* in the general meeting, which must be made the *de facto* governing body, and to resume, what it ought never to have handed over to the council, the administration of the Association.

If the general meetings are to win the confidence of the profession in Ireland, voice the opinions of the members, and rightly exercise supreme authority, they must be made representative assemblies. The organisation committee proposes that the election of representatives to the general meeting shall be a condition of branch recognition and existence.

If this be done, I anticipate that the annual general meeting shall cease to be a perfunctory performance, but shall become the working congress, the Parliament, of the Irish profession, in which all matters of policy shall be decided; devoting such time as may be necessary to enable all matters affecting the interests and the well-being of the profession, its relations to the public, the defects in the public and other services, inequitable to the medical officers and injurious to the efficiency of the services, together with questions of medical ethics and medical defence, to be fully and carefully discussed.

The council should be the executive committee of, subordinate and solely responsible to, and removable by, the general meeting, and should have only such powers as it may confer.

It should be composed of the best men the Association can pick out from its members; to secure regular attendance, economy, and the efficient transaction of business it must be reasonable in size, meet at least monthly, and, above all, it must do its own work.

The difficulty in the way of this simple and effective scheme of reorganisation arises from that blessed word representation, and the attachment of some, to the Association's Old Man of the Sea—the committee of council. On a small executive council, representation is illogical, out of place, impossible.

No man can serve two masters; a representative elected to the council by a branch or county cannot be responsible both to his constituency and to the general meeting. The general meeting being the supreme authority, the council must be subordinate and responsible to it alone; its members must not be at liberty to oppose the mandates or ignore the resolutions of the governing body. The representatives of a branch may be in a minority in the general meeting, and the representative on the council thus forced either to cease to represent his constituency or to oppose the will of the general meeting in the council; thus representation would create an opposition and destroy the responsibility of the council to the governing body. A representative general meeting and a representative council, if not directly antagonistic, would neutralise each other—would be quasi-co-ordinate bodies—and the situation would be worse than it is at present.

Representation must be proportionate to members; counties or branches with a large membership would not consent, and could not be expected to do so, to have an equal representation with counties having a membership of from eleven to twenty.

A representative council therefore means a large council, irregular attendance, a serious drain on the funds of the Association—if the expenses of the members attending be paid—and the perpetuation of the committee of council.

I am prepared to accept the provincial plan of the organisation committee as the best compromise that can be arrived at, but, like all compromises, it is defective. The voting power of one county might overwhelm that of all the others in a province, and to be equitable it provides for a larger council than is expedient.

I believe a council of fifteen would be amply effective as a working body, would be more easily controlled by, and would have a greater sense of responsibility than a larger body, to the general meeting.

I have seen no reason to alter my conviction that this small executive council should be elected either by the representative general meeting or by the entire body of members of the Association, preferably by the governing body to which it is responsible.

The contending views may be thus summarised:

I.—(*a*) Governing Body: Representative General Meeting.

(*b*) A non-representative Executive Committee, "The Council": Elected by the Governing Body or by the members of the Irish Medical Association.

II.—(*a*) Governing Body: Representative General Meeting.

(*b*) Quasi-Governing Body: A Representative Council.

(*c*) A Non-representative Executive Committee, elected by the Council.

I venture to submit that there is no need for a representative council to elect and stand between the governing body and the executive committee, that it only complicates the machinery, and divides responsibility; that the more excellent way is that by which the governing body elects and controls its own executive.

The Out-Patient Departments.

WESTERN GENERAL DISPENSARY.

Case of Aortic Disease with Cirrhosis of the Liver.

By R. O. MOON, M.D. OXON., M.R.C.P.,
Physician to the Dispensary.

C. M., a publican æt. 71, came up to my Out-patient department at the Western General Dispensary in November, 1904, with slight symptoms of dyspepsia. On examination the signs of aortic disease were very evident. The pulse was of very high tension and collapsing, there was a loud to-and-fro murmur all over the front of the chest, while the pulsating carotid arteries in the neck were most conspicuous. The whole arterial system showed considerable atheromatous degeneration, the arteries being, I think, the hardest and most tortuous I have ever felt. The heart showed only moderate hypertrophy but was well compensated. and the second sound was still audible over the carotid artery, a sign to which Sir W. Broadbent attaches a good deal of prognostic significance.

In addition to this condition of the heart the liver showed decided enlargement, reaching to within two inches of the umbilicus. It felt hard and tough, with little knob-like elevations which were doubtless the hobnails characteristic of alcoholic cirrhosis.

In a general way he considers that he has enjoyed very good health during his life of seventy years. From the age of thirty, however, to forty-eight he used to suffer from fits which were epileptic in character—losing his senses and biting his tongue. These attacks occurred on an average once a month, but he does not seem to have disturbed himself much about them nor to have undergone any regular course of treatment. During all this time he had been drinking rather heavily, his principal beverage being champagne, but also a moderate amount of beer and occasional nips of whisky. He was, however, never actually drunk according to his own account. It seems reasonable to conclude that the fits were due to alcohol and not to idiopathic epilepsy, as the first occurred after the age of thirty subsequent to his beginning to imbibe rather freely, and also there was no history of epilepsy in the family.

At the age of forty-eight he ceased to drink on the previous generous scale, confining himself to about a pint of beer per diem and a quite occasional whisky and soda, and has continued to do this to the present time. The cause of this reform in his habits was due not to any unpleasant symptoms which he wished to be rid of, or to the recommendation of doctors, but solely to the fact that he had retired from his business of publican, so that the facility for obtaining drink was less. This was certainly an instance in which "opportunity made the alcoholic." Now the interesting thing about this case is that with such extensive signs of disease in the heart, arteries, and liver, his symptoms are practically *nil*.

To take the case of aortic diseases first. It is well known that this lesion when contracted in early life as the result of rheumatic fever, has a relatively favourable prognosis, complete compensation being often maintained for a long period of years while the patient is able to engage in a life of considerable activity. But when the disease is produced by degenerative processes, as in our present case, the progress downhill is usually much more rapid. Here, however, no præcordial pain or attacks of dyspepsia, not even slight vertigo or palpitation betrayed the existence of his cardiac lesion. The main damage to his arteries must have been done between the ages of thirty and forty-eight, while he was drinking to excess, so it seems reasonable to assume that his aortic lesion has existed for upwards of twenty years without showing any symptoms of yielding compensation, which is certainly most unusual when the cause of this disease is not rheumatism but arterial degeneration.

Then with regard to the cirrhotic liver, the symptoms have only been an occasional slight dyspepsia, which has yielded to some quite simple line of treatment. There has been no ascites or haematemesis and yet the enlargement is considerable and must have existed for a long time. He remembers five years ago that a doctor came to see him once for indigestion and remarked that his liver was large, but the lesion must have existed many years prior to that, at the time when he was drinking heavily. The face does indeed present rather the appearance characteristic of the cirrhotic liver due to alcohol, for the skin is muddy and dirty looking, there is slight distension of the capillaries and the temporal muscles are wasted.

It is well known that cirrhosis of the liver may not infrequently be latent and is at times discovered accidentally *post-mortem*, but as a rule this only means that the patient has been cut off by some other disease before the cirrhotic process has had time to manifest itself. Here the lesion must clearly have existed for a very long time, and therefore it is quite unusual for the symptoms to be so slight as we have detailed. Cirrhosis of the liver is generally accompanied by a low tension pulse, and therefore does not tend to set up arterial degeneration; consequently the only relation of this patient's two serious diseases is that they own a common cause in alcohol. It is not quite easy to understand how it is that with two such grave lesions the case has run such a uniformly favourable course, more particularly as he did not give up alcohol or adopt any special line of diet or treatment of himself. On the other hand after retiring from business he reduced the amount of his alcohol to quite moderate dimensions, he was never a large eater and of late years has never required to make any great physical exertion, while at the same time having enough to do by taking on jobs as caretaker, &c., to preserve him from indolence. Added to this he is a man of an easy-going and tranquil temperament, never worrying about anything and being much amused at the amount of interest taken in his case when he feels so little ill.

It would be idle to speculate further as to the ultimate prognosis of an exceptional case such as this, but it seems worth recording as teaching that we need not take too gloomy a view of cirrhosis of the liver or of aortic regurgitation even when due to degenerative conditions.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, September 16th, 1905.

DIFFERENTIAL DIAGNOSIS OF CERTAIN OPHTHALMIC AFFECTIONS.

Dr. Wuillomenet, ex-President of the Paris Ophthalmic Society, has published an interesting article in the *Journal des Practiciens* on the differential diagnosis of certain diseases of the eye—conjunctivitis, keratitis, iritis, and glaucoma. It has happened, he says, to every ophthalmologist of a certain number of years of practice, to receive a patient suffering from ocular trouble who had been treated for some time for what was supposed to be conjunctivitis or iritis; and yet it was something quite different, a summary examination was sufficient to recognise immediately an attack of glaucoma. And the contrary was equally true, the patient was treated for glaucoma or iritis when the affection was less grave.

Conjunctivitis.—The diagnosis of conjunctivitis presenting an abundant secretion is attended with little difficulty. An error, however, might be possible where the conjunctiva was strongly infected and almost without secretion. However, an attentive examination will discover secretion in the inferior *cul-de-sac* in the form of very thin filaments; there exists a sensation of sand in the eye. The cornea is normal, the iris contracts freely before the light, and without perikeratic infection, generally speaking.

Keratitis.—Here the diagnosis offers in general no difficulty, for the inflammation of the cornea and the photophobia are constant. All the other symptoms are the same as those of conjunctivitis, especially where there is but slight secretion.

Iritis.—The same remarks might be addressed to iritis. Iritis can only be confounded with keratitis at the beginning. In iritis there is no lesion of the cornea, no ulceration nor swelling, but a more or less pronounced perikeratic infection. The ciliary vessels thus infected have no resemblance with those of conjunctivitis, which are voluminous, tortuous, mobile, and much less defined.

The pain is much more intense than in keratitis, but photophobia and epiphora are less pronounced. The pupil is small, reacts with difficulty to the light, and becomes irregular by reason of plastic adhesions; the iris loses its brilliancy, thickens, and exudation can be seen in the anterior chamber.

Glaucoma.—Any error in the diagnosis of this affection might be followed by disastrous consequences to the patient, and that by reason of the treatment employed. In every attack of acute glaucoma, the eye is red, the eyelids are swollen with chemosis sometimes, the cornea is cloudy and almost insensible to the touch. The pupil dilated, fixed, while the globe is almost of stony hardness. The pain of the eye radiates frequently through the whole head, and is often intense, depriving the patient of all sleep. Naturally the vision under those conditions is much compromised, and almost abolished.

In iritis, on the contrary, the pupil is generally contracted, the cornea is normal.

To resume: To diagnose glaucoma, the hardness of the eyeball must be first sought for, the dilatation of the pupil is readily observed. These are the two cardinal symptoms. The pain, the redness of the eye, the perikeratic infection, and the decrease of the vision are of less importance, being common with iritis. However, the symptoms are not always so clear; there are frequently very delicate cases presenting difficulties for even an experienced ophthalmologist. Then can be observed a certain kind of glaucomatous iritis when the tension of the eye is notably increased. Under such circumstances, it is necessary to examine the iris and not to forget that in the true glaucoma, the pupil is dilated and free from synechia, while in iritis the pupil is more or less fringed from the first day. In such cases, if the tension be increased, atropine is indicated, contrary to the teachings of certain ophthalmologists. But in glaucoma recourse should be had to iridectomy. The whole question may be resumed thus: Contracted pupil with normal tension, iritis; dilated pupil and eye hard, glaucoma.

Treatment of Acute Conjunctivitis.

The conjunctivitis due in general to the bacilli of Wecks is contagious. At the outset of the inflammation, antiseptic lotions are indicated. The lotion Dr. Wuillomenet employs is cyanine of mercury, 0·25 for 1,000 grms. of water. At the same time, and for eight to ten days, the following collyrium is instilled in the eye:

Sulph. of zinc, gr. v.
Water, drs. iiss.

If in a few days there is no improvement, recourse may be had to—

Protargol, grs. xv.—xxx;
Water, drs. iiss; or
Argyrol, grs. x. to xv.;
Water, drs. iiss.

These solutions are not painful and give satisfactory results.

Where the conjunctivitis is purulent and due to the gonococci of blenorrhagia, a solution of nitrate of silver should be employed:

Nitrate of silver, grs. v.;
Water, drs. iiss.

followed immediately by chloride of sodium, grs. xxx.; water, drs. iiss.

For Keratitis.—The same antiseptic lotion should be employed as for conjunctivitis, and the following ointment:—

Iodoform, grs. v.—x.;
Vaseline, drs. iiss.; or
Yellow oxide of mercury, grs i.—v.;
Vaseline, drs. iiss.

Where the perikeratic injection is pronounced, a solution of atropine should be instilled into the eye.

Iritis.—If the inflammation of the iris is acute with intense pain, four or six leeches to the temple will give good relief.

The atropine solution should be used at an early date, and

Strong mercurial ointment, drs. iiss.;
Ext. of belladona, grs. xv.

rubbed over the eyebrow.

If the inflammation is very acute, the following solution might be ordered:—

Sulphate of atropine, gr. j.;
Hydrochl. of cocaine, grs. iv.;
Solution of adrenaline m. xxx.;
Water (1—1,000), drs. iiss.

One drop in the eye every three hours.

Paracentesis of the anterior chamber may be indicated if the tension is great and the pain severe.

Glaucoma.—In acute or subacute glaucoma, iridectomy should be performed as quickly as possible, and from the outset of the attack four or five instillations of:

Hydrochl. of pilocarpine, grs. ij.;
Sulph. of eserine, gr. 1-5th;
Solution of adrenaline (1—1,000), dr. j.
Water, drs. j.

should be made daily. Besides their curative action they give great relief.

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, September 16th, 1905.

Epidemic Cerebrospinal Meningitis.

The epidemic of cerebrospinal meningitis, so often called (curiously enough) "spotted" fever in the daily papers, may now be looked upon as extinguished in Silesia. Since the disease first broke out on November 19th of last year in round numbers 2,950 persons were attacked and 1,600 died. In the whole of Prussia there were 3,250 cases and 1,750 deaths. Since sanitation has reached its present height of perfection typhus or "spotted fever," still known in England, I believe, has become very rare in Germany.

Conservative Myomectomy.

At the Vers. d. Aerzt., Zeuwald, Prof. Kronlein showed a patient on whom he had performed conservative myomectomy 16 years ago, the first on whom he had attempted the operation. The sexual functions had been completely retained. The tumour was as large as a 6 months pregnancy; it weighed 3½ kgrm. and it was growing from a wide pedicle, and was seated deep in the peneuchyma of the uterus. It was removed by Schroeder's wedge-shaped incision. The wound was closed by 49 sutures in three layers. Recovery was ideal. The operation took place in July, 1888; in November of the same year the patient married and her first child was born in December, 1889. Delivery was by the forceps. Since then she had had two other children, the last in May, 1892. At the time of the labour the cicatrix in the uterus could be felt. It was stated that the case was unique as far as literature was concerned, there being no similar recorded case.

The *Deutsch. Med. Zeitung* (91) has a reference on the subject of

The Influence of Serum Treatment on the Mortality from Diphtheria,

by Dr. E. Faber. The results of his investigations he summarises to the following effect:—

1. The serum treatment of diphtheria limits the relative mortality very considerably.
2. The diminished mortality depends on the power in the property of the treatment to work against the diphtheria intoxication, whilst the influence of the treatment on the stenoses and the lung complication is not so great as to overpower the other determining factors as regards statistics.
3. The earlier the treatment is begun in the disease the less danger there is of the patient dying of diphtheria intoxication. The danger of patients dying of descending disease or of pneumonia is about equal whether treated early or late.
4. As the cause of death in diphtheria cases is most frequently diphtheria intoxication, and that of croup cases is descending croup or pneumonia, the decrease in mortality shows itself in the diphtheria statistics and not in those of croup.

Embolic Affections of the Lungs after Abdominal Operations.

A paper on this subject by Dr. Gebele appears in the Beiwäge zur klin Chirurgie 43·2. Amongst the number of cases of lung mischief following abdominal operation in the Munich Klinik, which amounted to 6·43 per cent., 1·7 per cent. were due to embolisms. Besides the embolisms aspiration was the most frequent cause of mischief, then came hypostasis, then the narcotic itself (ether) cooling, and the direct invasion by micrococci.

Embolism of the lungs might follow any kind of abdominal operation and not certain kinds only.

Embolic pneumonia was a consequence of the infarct in about one third of the cases. Infective germs were necessary for the development of the pneumonia. The bacteria reached the lungs primarily with the embolus, but they might be secondary to it.

Embolic pneumonia which at first had a hæmorrhagic character before the formation of an abscess was insular and independent of the bronchi. The infarct was by preference subpleural.

The liver track as regarded the direct invasion of the emboli was to be excluded, it only came into consideration in regard to the bacteria. A secondary invasion of the lungs by hepatic emboli after purulent breakdown was possible. Only the anastomoses of the portal vein and the inferior vena cava allowed direct invasion of the lungs by thrombi. Post-operation thrombi might originate in vessels lying near to the field of operation.

Advances in Dermatology.

An article on this subject appears in the Deutsch. Med. Wocheusch. 29, 1905 by Privat-Dozent Klingmüller, Breslau. The most important novelty in dermatotherapeutics is said by the writer to be the Finsen light treatment. Valuable as it is for lupus of the face, however, it does not answer for lupus of mucous surfaces, for which so far the galvano cautery with subsequent painting with a 10 per cent. alcoholic solution of iodine and potassic iodide is the best. For the galvano cautery a platinum needle is used with which the lupus granulations, after being first flattened by pyrogallic treatment when they are abundant, are destroyed point by point. In hypertrophic lupus on the skin also the end is attained more quickly when the Finsen light is preceded by a not too intense Röntgen illumination or an application every 3 or 6 days of a 5 to 10 per cent. pyrogallic vaseline. This ointment is rendered more active and less painful by the addition of 5 to 10 per cent. of creosote and salicylic acid. In lupus of the trunk and extremities the safest and quickest treatment is still radical excision—cutting wide of the diseased parts, and deeply into the connection tissues below. The peripheral extent of the tuberculous infection he ascertains by means of the reaction zone set up by the injection of alt-tuberculin. The Finsen light was almost given up in the treatment of other dermatoses than lupus. As regards other " light " methods only the mercury lamp came into consideration ; this had been used with effect principally in cases of alopecia areata.

The freezing and hot air treatment of skin diseases and also the iodine-quinine treatment of lupus erythematodes of Holländer are thoroughly gone into. The re-introduction of theosinamine is highly spoken of by the writer as doing all sorts of good in cicatricial contraction, even if not in all cases. He recommends it especially in the form of plasters which may, however, set up a good deal of irritation.

As regards the arsenical treatment of various diseases (lichen ruber, psoriasis, mycosis fungoides, dermatitis herpetiformis, and sarcomatosis) the author prefers the subcutaneous injection of arsenious acid in a 3 per cent. solution of carbolic acid ; it acts well and causes comparatively little pain. He speaks very highly of tumenol in eczema. He uses it 1–10–20 per cent. with zinc paste in subacute and chronic cases, or withung. vaseline plumbi. Quite recently the Höchst Farbwerke have prepared a tumenolammonium which has been found very useful in the Breslauer Klinik. On account of its property of allaying itching it may be used in all pruriginous diseases of the skin.

The colourless anthrasol has proved a useful substitute for tar, but not to the exclusion of empyroform which does good service in eczematous and pruriginous skin affections. He recommends anthrarobin in the form of Arning's paint (Anthrarobin 2, Tumenol 8, Ether sulph. 20, Tinct. Benzoin 30) especially for the treatment of superficial furuncles. In place of ichthyol thigenol is now often used. Lenigallol as ½ to 5 per cent. zinc paste is especially useful in psoriasis-like and mycotic eczemas.

Of new useful ointment bases he mentions dermasan (especially for chrysarobine ointments) and the exceedingly mild mitine. As a dressing for wounds and ulcerations he makes use of 1 to 10 per cent. protargol ointments. For all painful affections he uses anesthesine extensively. Alcoholic dressings are also freely used. On the other hand Bier's stasis (artificial) hyperæmia, so useful in tuberculous and other suppurative diseases, he finds to be of very little value in dermatotherapeutics proper.

Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, September 16th, 1905.

Sensorial Aphasia.

At the meeting for internal medicine, Heller showed a case of sensory aphasia in a boy 10 years of age. The family history was good, but during the first year of childhood he had several severe convulsions, which grew less during the second year under bromide treatment. Teething and walking were very late, the latter about the fourth year. The general system was equally delayed ; when six years of age he could not understand what was said to him, nor could he tell what he wanted himself. He communicated with the family by signs and movements. He was about this time sent to school, but nothing could be done with him. In 1903 he was placed in a special school for teaching aphasic children, but with no more success. Since that time the lad has developed ; he is now reading and writing and the aphasia clearing off, while he can quite understand what is said to him and reply intelligently. The reading and writing exercise seems to hasten the power of speech. Previously the boy had no power to follow a song, but has recently acquired the ability.

Heller's explanation of this phenomenon is that the optical sensation with the sound of reading effected the results obtained. He referred to the different forms of memory in children and thought this circumlocutory method was not uncommon where writing fixed the impression while reading brought about the co-ordination of expression.

He considered the origin to be due to the convulsions in the first year of childhood, which disturbed the centres and paths of speech and finally paralysed the function.

Ungar asked if the child ever suffered from adenoid vegetation. Heller responded that it had, which he removed without success. No change of the psychical condition could be observed. Another colleague prescribed thyroid gland which was taken for several weeks without success.

Eschesich asked what his prognosis was, to which he replied that the expectation was good from the progress already made.

Urticaria Xanthelasmoidea.

Noble exhibited to the members a child 2½ years of age with Tilbury Fox's xanthelasmoidea. According to the clinical history of the case the commencement dates from the fourth month of the child's existence, as an eruptive red elevation on the trunk, which subsequently became dark coloured and plateau like.

About the end of the first year the rash appears to have reached its zenith and since then has remained unchanged in spite of every remedy that has been tried. The pathology of the disease, according to Unna, is that the whole process is a deposition of Ehrlich's complex giant cell in patches as neoplasms in the subepithelial tissue.

Histologically it resembles in many particulars a nevus, where an abnormal collection of fine granular melanotic pigment takes place in the upper layer of the cutis and trabecula of the papillary sheaths. It is pathognomonic of the disease that no dermatose disturbance beyond this colouration is present which, with the clinical history of childhood, and no change in its appearance for years confirms the diagnosis.

Congenital Pulmonary Stenosis.

Goldreich demonstrated stenosis in a child 15 months old, which appeared to be congenital. The heart was enlarged towards the right with a systolic murmur in the third intercostal space and great weakness in the second pulmonary sound. The rays confirmed the enlargement, and revealed a loss of expansion in the arteria pulmonalis.

Hochsinges thought the case interesting from the complex systems presented. The weak second pulmonary tone was sufficient of itself to prove the stenosis without the eccentric hypertrophy of the right ventricle.

Poliomyelitis.

Lehndorff exhibited a curious case of poliomyelitis with hand progression. The lower limbs were flaccid but strongly bent on the hips with lordosis of the lumbar portion of the spine. The upper part of the body was abnormally well developed owing to carrying the whole of the lower portion of the body. The manner of fixing the pelvis and lower limbs producing the lordosis assisted the youth to fix the legs like stilts by which locomotion was practicable though curious.

Spina Bifida Occulta.

Spieler showed a boy, aet. 11, with bladder and bowel disturbance without any other marked symptom to show injury to the cord, or malformation. Enuresis nocturna, and occasionally involuntary motions were the principal symptoms. The urine was more profuse by night than by day or in the upright position. Digital examination revealed paresis of the sphincter and detrusor vesicæ. No other portion of the nerve system was affected in either motion or sensation. On examining the sacral surface over the third and fourth vertebra a soft elastic tumour about the size of a walnut and loculated was discovered. In the skin covering the part were small tubercles depressed in the centre. In palpating the part in the neighbourhood of the tumour an opening could be found in the bony structure, from the margin of which a membrane stretched across the opening, closing the hiatus in the sacral canal. The finger could be pressed in past the nerve structure to the anterior surface of the spinal canal. The Röntgen rays confirmed the diagnosis. He considered an operation was indicated in this case, and would greatly improve the condition.

Riot by Hospital Patients.

The large general hospital at Lemberg was the scene of a regrettable uproar last week. Some of the patients had become possessed with the notion that they were being kept longer than was necessary, especially objecting to the deprivation of liquor. They induced their friends to smuggle in spirits, and then demanded to be allowed to leave the hospital. This being refused, they attacked the doctors and nurses, who had to send for the police, and the disturbance was only quelled when five of the most violent of the patients had been placed in charge of the police.

Hungary.

[from our own correspondent.]

Budapest, September 16th, 1905.

At the last meeting of the Society of Physicians, Dr. A. Rosenberg reported hitherto unnoticed sequelæ resulting from

The Use of Suprarenal Extract.

The patient, a young woman in good physical condition, presented what appeared to be symptoms of an accessory nasal sinusitis. A small swab saturated with suprarenal extract was applied to the swollen inferior turbinate. It brought on an unpleasant disturbance of smell, and within a few hours was followed by a diffuse urticaria extending over the trunk and arms. This disappeared after a short time, but about a week later, when the treatment was repeated, the same trouble reappeared. Swabs saturated with water or cocaine failed to produce the same effect. The author believes that this urticaria was caused either by absorption of the drug or was a reflex disturbance brought about by an irritation of the olfactory nerve, the patient complaining of an unpleasant sensation of smell at the time when the suprarenal extract was applied.

Dr. Crejte, in a case where epilepsy had proved fatal, found the cortex of the brain the seat of a number of cavernous angiomata, the largest of which were surrounded by calcified connective tissue. They were probably congenital, since the epileptic seizures began in earliest youth. Their relation to epilepsy can hardly be explained by variations in intracerebral blood pressure, since experimental venous stasis, even in epileptics, never brings about an attack, and since compression of the carotids in animals is never followed by convulsions. It is more probable that they irritate the cortex by their constant growth. Angiomata of the brain are rather rare, but have been found in several previously reported cases of epilepsy.

Operating Theatres.

NORTH-WEST LONDON HOSPITAL.

Operation for Fulminating Appendicitis.—Mr. Jackson Clarke operated on a girl, æt. 9, who had been admitted for acute abdominal pain which had begun suddenly forty-eight hours previously, when the child was sitting at stool. The onset of pain was so severe that the girl was said to have fainted. On admission to hospital, the patient's temperature was found to be only 96°, and the pulse-rate 160°. When put to bed with warm bottles, &c., the temperature did not rise to normal, but the pulse-rate increased to 180. The child was restless and complained greatly of thirst, but the lips and face were not blanched. The respirations were shallow and rapid, and *the whole of the abdomen was held absolutely immobile in respiration.* On palpation, the recti and other abdominal muscles were felt to be tense and resistant, and the patient, although too far collapsed to take much notice of her surroundings, appeared to resent palpation of the lower part of the abdomen. A warm enema, which had been administered some time previously at the hospital, brought away a fairly copious evacuation of fæces. There was a history that two years ago the child had been treated for tuberculous peritonitis. Before operating, Mr. Clarke said that the absolute immobility of an abdomen free from distension was almost pathognomonic of acute peritonitis, and, in spite of the subacute temperature which he attributed to shock, it was his opinion that the child was probably suffering from fulminating appendicitis; although, he pointed out, two other conditions had to be considered. One of these was acute obstruction high up in the small intestine, and the other was an embolism of the superior mesenteric artery. The first of these, he said, was excluded by the fact that vomiting was not a prominent symptom in the case, the child only having vomited twice since the onset of the attack; the second, he thought, was eliminated by the fact that the child's lips and cheeks were of a fair colour and not blanched as they would have been in a case of infarction of the whole of the small intestine. The child was anæsthetised, and the front of the abdomen prepared with a solution of mercuric biniodide in methylated spirit, 1 in 500, subsequently washed off with 1 in 40 carbolic lotion. Palpation of the abdomen under the anæsthetic did not reveal any tumour in the region of the appendix. The incision was made in the middle line below the umbilicus. This brought to light a normal small intestine, so a second incision was made over the appendix. On opening the peritoneum here, some blood-stained pus and a larger quantity of thin brownish liquid with a fæcal odour escaped, such as is often met with in cases of acute appendicitis with a sloughing appendix. The appendix was not seen, but it felt slightly, if at all, harder than normal. The extremely grave condition of the patient made it inadvisable, Mr. Clarke pointed out, to do more than completely drain the region of the appendix and the pelvis. Mr. Clarke said he was afraid that the patient was doomed, and that a *post-mortem* examination alone could tell exactly where the intestine had given way. He was unable to detect any evidence of perforation of the appendix, and he was sure that if the operation had been prolonged it could only have resulted in the death of the patient on the table. The free drainage established gave the child, he considered, the one slight hope that was left, but if there should be an opportunity of making a *post-mortem* investigation, it was a case in which this ought to be done. Mr. Clarke mentioned a recent case, on which he had operated forty-eight hours after onset, of acute appendicitis in a young woman, where he had removed a sloughing appendix and established a drain from the flank through the roof of the vagina (Douglas's pouch being full of fæcal smelling effusion). In that instance a rapid and complete recovery had taken place, but in that case there was none of the severe collapse that marked the condition of the little patient on whom he had just operated. The child was put to bed and a rectal injection of half a pint of warm saline solution was administered. In spite of this and other measures taken by the senior resident medical officer, Dr. Bell, the girl died a few hours after the operation. The *post-mortem* subsequently made by Mr. Hayes, the junior resident medical officer, revealed a small perforation in the ileum close to the appendix, and probably at the site of a small tuberculous ulcer in one of the solitary glands. Except in the left iliac region of the pelvis, there were numerous adhesions in the abdominal cavity, evidently the result of the tuberculous peritonitis for which the patient had been previously treated at the hospital by Dr. C. O. Hawthorne.

The annual congress of German scientists and medical men is to be held at Meran in the week beginning September 24th. It is announced that 144 persons have entered their names as proposing to attend the scientific sections.

The number of persons under care as duly certified insane on January 1st, 1905, was 119,829, being 2,630 in excess of the number recorded on the same day in 1904. The increase in 1904 was mainly in county and borough asylums.

The Cork Joint Hospital Board have now sufficient money at their disposal to proceed with the establishment of a sanatorium for consumption. A meeting was recently held at which a site was decided upon. The size and form of the sanatorium is to take is not settled.

Dr. E. Symes Thompson, Gresham Professor of Medicine, will deliver a course of four lectures on "The Prevention of Infection," at Gresham College, Basinghall Street, on October 3rd, 4th, 5th, and 6th, at 6 p.m. each day. These lectures will be illustrated, and are open to the public without fee.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, SEPTEMBER 20, 1905.

CHOLERA OUTBREAK IN GERMANY.

The present limited outbreak of cholera in Germany need not give ground for undue alarm in this country, but without doubt it demands that alert and rigorous measures shall be taken in hand to prevent the disease from reaching these shores. Without official information it is not possible to gauge the full extent of the outbreak and its chances of dissemination, for the German Government, for the sake of trade and communication, are likely to put the best face on things, and to take an optimistic view of the efficacy of the repressive measures they are adopting. There is no reason to think that anything that the science of hygiene can suggest is being left undone, for not only is Germany well in the van of scientific progress, but in a country where officialism and militarism hold the populace in check, it is far easier to carry preventive measures to their logical conclusion than in Great Britain, where the line between personal freedom and selfish licence is not readily appreciated by a large class of the community. Against the many and undoubted benefits of popular government there has to be written off a large amount of waste of energy and clumsiness of machinery, and this is particularly apparent in military policy and preventive medicine. The sweets of democracy are not unalloyed with bitters. We have, however, reassuring evidence that the medical department of the Local Government Board is alive to the danger of the invasion of these shores, and that it is ready to adopt all necessary precautions against such an event. The anti-cholera policy of the Board was brought to a high state of perfection under the late Sir Richard Thorne Thorne, and his successor, Mr. Power, has shown in more ways than one since he assumed the *role* of chief sanitary adviser to the Government that the mantle has fallen on no unworthy shoulders. We can, then, look to him with every confidence to do all that can be done to guard our ports against a very terrible danger. The experience of 1892 is still fresh in the minds of most sanitarians. In that year cholera raged with great violence at Hamburg; some 18,000 persons were attacked and between seven and eight thousand deaths occurred. Hamburg being as it is one of the greatest centres of international shipping in Northern Europe, and one in daily communication with our eastern and south-coast ports, presented a constant and real menace to the whole of England, as was shown by the fact that cases of cholera actually reached Hull, Gravesend, and Middlesbrough by direct importation. The medical department of the Local Government Board, however, by stirring up the port authorities, constituting temporary authorities where needful, keeping in telegraphic communication with all centres of shipping, and detaching a special staff of its own inspectors to visit the coast towns, were able to institute a cordon through which no cases of cholera managed to penetrate further than to the isolation hospitals at the ports which received them. All this, too, was done without exasperating quarantine regulations and without any dislocation of the normal shipping trade. We learn at the present time that although the public attention is being principally directed to the inland cases in Germany, cholera has already reached the Baltic by way of Russia, so that it is not at all unlikely that some of the ports, from which so vast a trade in food-stuffs is carried on with this country, may be definitely infected. If this be the case, only the greatest care and vigilance will preserve our shores, and we hope in that event that no expense will be spared in providing adequate safeguards against invasion. It is a sign of hopeful augury that the summer is now far spent, for cholera is a hot-weather disease and does not readily survive cold and frost. Still, it must be remembered that in the great pandemic of 1826-34, Edinburgh was not affected till January, 1832, and London till the following February; so that even with the advent of winter all danger cannot be held to have passed away. The present epidemic seems to have followed much the same course which all epidemics have followed with "damnable iteration." Before the "civilisation" of India, cholera, according to all accounts, was confined to that country; it never seems to have crossed the Himalyas or to have spread across the sea. The delta of the Ganges and the marshy districts of Lower Bengal have time and again been shown to be the endemic home of cholera. Thence it spreads in epidemic years to the northern parts of India, southwards to Madras, and westwards to Bombay. Except that occasionally cholera is carried by shipping to China, Egypt, and Arabia, it generally follows the trade routes over the Himalayas through Persia and Afghanistan to Southern and Eastern Russia, and thence over the continent of Europe, even to America. Six or seven times in the last century Europe was thus invaded with appalling effect. It is impossible, in the light of all that is known, to acquit the Indian Government of all share in the responsibility for outbreaks of recent years, for though doubtless they are unwilling to see their country devastated by these epidemics, they make no show of attacking the disease in its endemic stronghold. Even failure after a great effort would be more creditable than to sit passively gazing at these repeated and ghastly epidemics. The ill-feeling engendered in the eighties against the Indian Government has not yet wholly died out, nor has the memory of the haughty tone and official subterfuges with which they defended themselves. A determined attempt to deliver the world from the constant menace of cholera would present the Indian Government in a more favourable light than do internecine disputes amongst its high officers as to which one shall have certain subordinate departments under his charge.

HUNGER.

What is hunger? The question is almost as difficult as that put long ago by the jesting Pilate, to which no answer has yet been found. It is, indeed, curious that a fact so elemental in life has received so little systematic attention from students of the science of life. A search through the writings of physiologists will show either that the question has received no attempt at an answer, or that the answer, however large it may be writ, is insufficient. One distinguished writer on diseases of the stomach sums up his knowledge in the remark worthy of Sir Roger de Coverley, "The physiology of appetite is therefore complicated." A representative text-book of physiology, which devotes fourteen lines to the entire subjects of hunger and thirst, says, perhaps not as truly as is apparent, "Some condition of the empty stomach arouses hunger." Such dicta are indeed typical of the attitude of mind adopted at present by what may be called, to borrow an ecclesiastical term, "safe men." In the first place, there is no consensus even as to the site where hunger originates. One of the quotations just given places it in the stomach, but there are many writers who place it elsewhere. Thus some state that hunger, far from being a sensation rising within the stomach, is the expression by the tissues themselves of the need for food, while others suggest that there are certain groups of cells in the medulla which produce such sensations as hunger, thirst, and satiety. Pawlow, to whom at the present day everyone looks for light and leading on all matters relating to the physiology of the stomach, fully recognises the importance of appetite from a scientific point of view, and devotes much space to it. Nevertheless, as regards the particular question we are now discussing, we feel that we come out by the same door where in we went. Moreover, even if it be admitted that hunger is situated, as regards origin, in the stomach, the difficulty of the problem is by no means ended. Is hunger simply the psychic impression of the physically empty stomach? Apparently not, for one may be hungry even with a full stomach. Moreover the assumption of the gastric origin will not itself stand, for it has been shown that hunger still occurs after excision of the entire stomach. Dr. Mark Knapp, who is perhaps the most recent writer on the subject (*a*), argues strongly in favour of the doctrine that hunger is the pain caused by contraction of the muscular coat of the gastroduodenal section of the alimentary canal. He points out the well known occurrence of excessive peristalsis in fasting animals, and he explains the subsidence of hunger after a time, even when food has not been taken, as due to muscular fatigue. The sudden appetite felt as the result of such a stimulus as a cold drink or a bath is said to be due to muscular contractions caused thereby. The gap in Dr. Knapp's argument is, of course, the failure to show why or how abstention from food for a certain length of time causes gastroduodenal contraction, and why such contraction occurring after a full meal does not give rise to the sensation of hunger.

Notes on Current Topics.

Deaths under Anæsthetics and Coroners' Inquests.

It is, we believe, a right and proper thing that deaths under anæsthetics should as a rule form the subject of coroners' inquests. Nothing could be more injurious to the confidence of the public in the medical profession than for a belief to get abroad that medical men have anything to conceal in the unfortunate circumstances of a death on the table, or that there is on the part of those in charge a desire to hush up the facts of the case. The confidence of the public is the breath of the nostrils to a surgeon, and in order to maintain this confidence he must show himself ready to meet all legitimate inquiry into the facts of any fatality which may mar his practice. In conducting courts of inquiry in such cases, however, a coroner should remember the limits of his duty, which is to discover the cause of death, that is to say, to satisfy himself that every possible care was taken to avoid ill results. Most coroners fully recognise this and keep themselves strictly to the question before them, but, unfortunately, here and there one adopts the attitude that death under anæsthesia is *prima facie* an evidence of negligence. "There is no evidence of criminal inattention except the fact that the man died," was the remark made by a Melbourne coroner in the course of an inquest the conduct of which has roused much feeling in the Colony. The adoption of such an attitude, besides being manifestly unfair to the anæsthetist and surgeon, renders the coroner who adopts it quite unfit for the duty he has in hand. Moreover, it must be remembered that the publicity given to sensational reports of the doings at coroners' inquests may be injurious to the public good in creating a distrust of anæsthetics. Considering the number of operations which have to be performed nowadays, and the fact that fear is one of the strongest predisposing causes of fatality, it cannot be good to create in the public mind a false belief that the administration of an anæsthetic is lightly undertaken or negligently carried out.

Decline of the Birth-Rate in America.

Statisticians in America are beginning to draw attention in very emphatic manner to the serious decline in the birth-rate evident in that country. Were it not for the constant influx of emigrants the population of the United States would be, like that of France, stationary, if not actually decreasing. That this is not a satisfactory state of affairs is fully recognised by responsible public men, many of whom, including President Roosevelt himself, are devoting serious consideration to seeking a remedy. The decline in the birth-rate is by no means of quite recent origin, for a bulletin just issued from the Census Bureau points out that it has been persistent since 1860, and that, though subject to many fluctuations, a fairly steady decline is to be traced from the beginning of the nineteenth century. A hundred years ago, the children under ten years of age constituted one-third, and now less than one fourth of the entire population. The figures which are given in comparison of the fecundity of native and of foreign women in America are striking. The standard adopted is the number of children under five years of age in proportion to the number of women of child-bearing age. It is found that whereas to every 1,000 foreign born women between the ages of fifteen and forty-nine there are 710 children, to every 1,000 native American women there are only 462 children. The fecundity of negro women is greater than that of whites, though the disproportion is not so great as it was twenty-five years ago.

Brain Foods.

A recent vigorous article in the *Young Man* from the pen of Dr. J. Robertson Wallace strikes a note so consonant with commonsense and common experience that we hope it may make some sort of impression. The writer opines that if a fraction of the energy which the British youth now devotes to the training of his muscles were expended on cerebral gymnastics, less would be heard of British backwardness in the path of commercial progress. He points out that to-day more than ever the brain is "the thing," and that to develop the brain should be the aim of all who are struggling for existence. Like other tissues, that of the brain becomes more efficient and powerful with exercise, but this exercise calls forth a greater degree of effort than that of any other tissue. It is by effort, exercise, and sleep—duly apportioned—that the brain is developed, and not by buying patent "brain foods." There are no foods which have a special influence on the brain, any more

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(a) *American Medicine*, August 26, 1905.

than there are foods for the heart, lungs, or kidneys; the brain selects from a mixed diet those elements which it needs, and rejects all others. "Patent brain foods," says Dr. Wallace, "are a delusion and a snare; a man may cram himself with fish and phosphates until he becomes luminous in the dark (if that be possible), and yet remain to the end of time as incapable of comprehending the first problem of Euclid or the last joke in *Punch* as he was on his first birth-day." The readers of the *Young Man* at least have the truth put before them.

Quinine in Corneal Ulceration.

A practical paper appears in the *Journal of Ophthalmology* on the treatment of corneal ulcers by means of quinine. Mr. Arnold Lawson, the writer, points out that at present quinine is used only for a small class of affections of the cornea and conjunctiva, but in his experience it may be employed for a number of different kinds of corneal ulcers to which stringent methods are generally applied. Mr. Lawson recommends a one per cent. solution of the sulphate with just sufficient sulphuric acid to dissolve the salt, and he has found this preferable to either the acid sulphate or the hydro-chloride which, of course, are soluble in water. Irrigation of the eyes with this solution causes but little discomfort, and it is recommended that they should be well soaked in it for five minutes four or five times a day, with one thorough irrigation in the twenty-four hours. By this means Mr. Lawson has seen troublesome ulcers heal in a week, and most cases rapidly improve. If no improvement is shown in a few days, it is probable that the result will not be satisfactory, but in any case it should be persisted in for a week. From the list of cases related in the original paper, it appears that a valuable means of treating corneal ulcers has been found, and it is so simple that it is worth a trial before adopting drastic procedures.

Magnificent Prize.

The South American Republics are not generally looked upon as centres of light and leading; people usually regard them rather as centres of yellow fever and revolutions. But while European States are busy talking about their progress, Brazil, at any rate, has come forward with a proposal that is likely to stagger them all—not only for its munificence, but for its enlightenment. This is no less than the offer of a prize of £400,000 to the man who can discover a certain means for stamping out tuberculosis, or, it is added, of syphilis or cancer alternatively. The actual money would appear at present to be the property of an individual, but in the event of the proposal being accepted by the Government, a representative committee of Brazilians, French, German, Italian, and English savants is to be appointed to adjudicate. For the prize is to be open to the competition of the whole world, and not to be confined to native scientists. Here, then, is a chance, the first in the world's history, whereby a man who confers a great blessing on his fellow-creatures can hope not merely for empty-handed gratitude, but for riches in abundance. While scientific workers in Europe are lucky if they make a few hundreds a year to live on, Brazil offers a sum that may make one of them more wealthy than his wildest dreams can ever have suggested.

Sanatorium Village.

An interesting development of the sanatorium principle appears to have taken place near Lille, France, a district which is one of the centres of the coal-mining industry. The employers of labour have at their own cost erected for their workers a sanatorium which is more of the nature of a colony than of an institution. There is a large building for single women and another for single men, but the unique feature of the establishment lies in the provision of a group of twenty-four villas for married people with families. It is intended that a worker who contracts tuberculosis shall not be deterred from treatment by being separated from his family, nor that the family shall suffer by being deprived of his society. The regulations of the sanatorium only enjoin six hours treatment a day by fresh air and rest, so that it is not likely to find favour with those who believe in the whole hog or nothing. It is not a little remarkable how many modifications have been introduced into sanatorium treatment since it first became fashionable; each institution and each medical superintendent is a rule unto itself, the name "sanatorium" covering all the different methods. Just as Weir-Mitchell treatment has degenerated from a six months' course of solitary confinement to, in some cases, a few weeks' rest and rubbing, so Dr. Walther would hardly recognise his system as carried out by some of his professional followers.

Chocolate as Food.

One of the dietetic reforms that is slowly yet surely being taken to heart by the public at large is the consumption of food in less bulk but in a more concentrated form. Armed with the necessary tabloids the average citizen can prepare a meal with the aid of a kettle of boiling water. Another food-habit which is steadily growing in favour among adults is sweet-eating. The choicest confections may, however, be consumed not wisely but too well, with the result that the foundations are laid of dyspepsia and allied gastric disorders. The blunting of the healthy appetite by eating sweetmeats between meals is well known to all who have charge of the young, not to speak of probable injuries to the teeth, whereby premature decay is induced. Apart from these consequences there is much to be said in favour of taking pure chocolate as a means of supplying easily assimilable nourishment in a convenient form. "It is hardly possible," says Bunge, "to carry food in a more concentrated form than in chocolate." The words of this distinguished physiologist, uttered many years ago, are now beginning to bear fruit. Modern investigators have shown over and over again the value of sugar as a real muscular food, while chocolate with its contained proteids may lay claim to exceed pure sugar as a nourisher and sustainer of the body. At the Confectioners' and Bakers' Exhibition, held recently in London, the idea was expressed by a well-known manufacturer that the increased consumption of sweetmeats by adults may help to explain the falling off in the sale of alcoholic liquors. If this be true, the public is to be congratulated upon its choice. The incorporation of milk and cream with chocolate, now much in vogue, serves to enhance still further the food-value of this deservedly popular sweetmeat. The late Queen Victoria was a great believer in the sustaining qualities of chocolate; witness the Queen's chocolate boxes distributed to the soldiers in the South African War.

Tuberculosis Congress.

The 1901 Congress on Tuberculosis was a distinct success, both as regards its scientific work and the service it rendered in attracting public attention to the social problems of tuberculosis; in fact, all who attended the gathering agreed with the sentiment intended by Professor Bronardel when he announced that the Congress had far exceeded everybody's "expectorations." The second Congress of the series is to be held in Paris next month, and the interest manifested by the State in its proceedings is shown by the fact that the President of the Republic and MM. Bourgeois and Casimir-Perier are giving active support. M. Loubet will give a reception; as will the Municipality of Paris and the President of the Congress; a banquet will be held, and the President of the Republic himself will perform the opening ceremony. The Congress will work in four principal sections; that of Medical Pathology, under Professor Bouchard; that of Surgical Pathology, under Professor Lannelogue; that of the Preservation and Assistance of the Child, under Professor Grancher; and finally that of Social Hygiene, under Senator Paul Strauss and Professor L. Landouzy. It is satisfactory to note that the British representatives are all experienced and practical men who command the respect of the profession over here, and that Sir William Broadbent is presiding over the British Committee which is working up the interest here. There seems every prospect of a well-attended and enthusiastic gathering, but one is inclined to wonder if the congress business generally is not getting a little overdone.

Origin of Living Matter

Dr. Charlton Bastian is impenitent as regards spontaneous generation, and he has, in the September number of the *Independent Review*, an article reaffirming the faith that is in him. Whatever may be held to the contrary by scientific men in general, it is impossible to refute or disprove Dr. Bastian's argument, which is self-contained and not opposed to evidence. On the other hand, it needs some definite and fresh facts before Dr. Bastian's theory can be held to have attained plausible demonstration; at present it remains a theory only. We confess to not being much impressed with recent experiments on spontaneous generations. Sir William Ramsay has done Mr. Burke the honour of a serious criticism of his published work, and in it he has elaborated the ingenious theory that the radium in Mr. Burke's experiments generated "emanation" (that is to say, helium) whereby bubbles were formed in the bouillon-gelatine. These bubbles would be coated by coagulated albumen and would contain hydrogen and oxygen—from decomposed water together with emanation. As these gases expanded, the envelope would burst and a bud would be produced, which in its turn would produce similar buds, and so on for a long period of time. The bodies thus formed would be the apparently-living "radiobes." Whatever be the explanation, that of spontaneous generation must be the last one admitted, as being the least likely, even though so much of Dr. Bastian's theory as applies to the original appearance of life on the globe—archebiosis—must be admitted by all who hold the evolutionary hypothesis in its entirety.

The Sterilisation of Catgut.

The reliable sterilisation of catgut is a procedure of considerable importance to the operating surgeon, and any new methods of effecting the desired end are consequently of interest. The most recent method to be suggested is one brought forward by M. Beslier, a French *pharmacien*. He recommends that the gut be first rolled on glass bobbins, and then placed in a copper bomb containing crystallised benzine. The bomb is closed by means of a screw and is then placed in an autoclave, and the benzine is boiled for twenty or twenty-five minutes in order to remove all fat and at the same time to dehydrate the gut. The bobbins are then placed in an unclosed flask, and this is immersed in another copper bomb also containing benzine and closed by a screw. This bomb is heated in a stove until a pressure of two atmospheres is indicated by a manometer, and then the temperature is gradually lowered. This procedure lasts from an hour and a quarter to an hour and a half. The screw on the bomb is then replaced by a plug of cotton wool, and the bomb is heated on a sand bath, with the result that the benzine vapour is gradually replaced by one of filtered air. Finally the flask is removed and alcohol poured into it. This is a complicated procedure, and to become popular must offer some great advantage. The method of sterilising catgut under pressure in non-aqueous fluids is an old one. So far as we know, it was first introduced by Dr. Fowler, an American surgeon. His method of sterilising in alcohol in glass tubes was made of more general applicability by the introduction of a brass steriliser with a screw top by Dr. Henry Jellett in 1897, and the latter procedure was in turn varied by Mr. Mayo Robson, who recommended the sterilisation of the gut in xylol in a similar steriliser to that previously introduced by Dr. Jellett. Both alcohol and xylol sterilisation ensure sterility but unless they are carefully carried out they are apt to weaken the gut, and in consequence many surgeons have abandoned them for the formalin method. M. Beslier's procedure, save for the difficulty of carrying it out, seems to offer some advantages, as the gut so sterilised, when tested by means of suspended weights, was found to maintain its original strength.

Superficial Study.

It may not be out of place at this season to point out to the embryo medical student one of the commonest dangers that beset his path, which may one day mar his future success as a practitioner. We refer to the mental habit of superficiality in study. Nothing can be more disastrous to the acquirement of real knowledge of a subject than lack of thoroughness and the determination to sift a matter to the bottom. The problems of medicine and physiology are multitudinous and deep, and they cannot be solved by skimming the pages of a text-book or by listening half-heartedly to the points of a lecture. The side-issues of medical science are both numerous and attractive, and it may be, as Professor Osler says, that "there is too much wayside fruit in our educational system." The student will do well to avoid the by-paths and shady lanes of study that excite his curiosity and invite his halting steps, but which only too frequently lead nowhere in particular. Though it is true, of course, that the broad outlines of a science must be grouped before details can be properly studied, yet it must be borne in mind that generalisations can never take the place of careful weighing of knotty points. It is concentration that pays, and the student will soon find out that he has not lost time in making himself thoroughly conversant with the more difficult parts of his subject as well as with those that are more easily understood. This applies as much in the dissecting-room and the chemical laboratory as it does a few years later in the wards or the post-mortem room. The superficial man, though he may be brilliant, will, nevertheless, lack that calmness and self-reliance which will stand him in such stead afterwards, and which only comes to the followers of the Ciceronian precept—"*Quicquid agas, agere pro viribus.*"

"A Little Knowledge."

The commendation of a police officer by a coroner's jury for having administered an emetic to a person suffering from oxalic-acid poisoning, reported in the daily press, affords yet another instance of the credulity of the public in matters medical. Whether the officer in question were to blame in adopting this mode of treatment or not, we cannot tell without knowing the full facts of the case. The first-aid treatment of poisoning is not easy for the amateur, for even men in the public service do not meet such cases every day, whereas the "ambulance-man" becomes quite an expert, from frequent practice, in the art of bandaging and the application of temporary splints. Oxalic acid, though corroding the œsophagus and stomach, is not generally classed as a corrosive poison, but merely as an irritant, which is apt to be somewhat misleading to the student of toxicology. As a matter of fact, the first-aid treatment of acute poisoning amounts to this: "If there are no stains about the mouth, give an emetic"—advice which is sound enough as far as it goes. Unfortunately, however, oxalic acid does not leave stains at the corners of the mouth, though its action as an internal corrosive is obvious enough to those who have seen the organs in a fatal case of poisoning by this substance. Where the difficulty lies is when the nature of the poison taken is unknown. To the professional man this is often grave, but to the amateur who has only attended two or three lectures upon poisons and their first-aid treatment it is far greater. Small wonder it is, therefore, that pardonable errors of judgment are not committed with more frequency. It is not safe to give emetics if oxalic acid has been swallowed, even if there be no vomiting. The wisest plan is to administer chalk and water freely, with stimulants if necessary.

Venesection Revived.

The revival of old fashions is almost as prevalent in medicine as in millinery. A short time ago we were threatened with a re-introduction of the crinoline, but, for obvious reasons, this is not likely again to meet with popular favour. By degrees we are beginning to learn that not all that is old-fashioned is stupid or useless; indeed, it is curious to observe that modern science is continually discovering justifications for certain older methods of treatment. Dr. R. I. Ewart, in a recent paper read before the Manchester Medical Society, has found that the practice of venesection is often physiologically indicated. The habit of blood-letting is one which is still associated in the minds of some with mediæval medicine, recalling the good old days of the physician with his gold-headed cane. It is true that it may appear irrational to bleed "at the spring and fall," no matter whether the patient be sick or well, but there is no evidence to show that any real harm ever came of this practice. The swing of the pendulum in the reverse direction has resulted in postponing the application of this valuable remedy until too late in the course of the disease, when the over-loaded heart is unable to recover its balance Dr. Ewart's researches show that the principa.

effects of the withdrawal of blood from the circulation are a decrease in the number of corpuscles per cubic millimetre, a fall of fluidity, and a withdrawal of lymph from the tissues. In states of asphyxia, such as prevail in some forms of heart disease with broken-down compensation, the normal gaseous exchange is greatly deficient and there is also an increase in the number of erythrocytes. When this is the case and when the general circulatory system possesses sufficient vitality to make up the quantity of fluid lost by withdrawal of lymph from the tissues, venesection is expressly indicated. It has also proved beneficial in the asphyxial condition when anæsthetics are badly borne.

Prison Congress.

LAST week the periodical congress of the International Prison Association was held in Budapest, and representatives from all civilised countries were delegated to attend. The new theory of prison-treatment for criminals may be held to date from the first of the congresses in 1872, for although most of the penal establishments of the Western nations had by that time been purged of the grosser brutalities of previous ages, the scientific reclamation of convicts still remained more or less of a dream. That England or any other country has attained to any adequate realisation of that dream it would take a bold man to assert, but with the disappearance of the lash for all but the gravest offences, the suppression of the useless tread-mill, and the abolition of that refined act of vengeance, solitary confinement, the dawn of a new era may be held to have begun. Sir E. Ruggles-Brise, Chairman of the Prison Commissioners, read a paper on the changes in the English system during the last five years, a period which will for ever be characterised by the introduction of the Borstal experiment for juvenile-adults. The success which has attended this innovation has already been striking, and it is much to be hoped that it may be developed till even the senile adult comes within the sphere of its operation. Although England has done much to advance humane and sensible treatment in prisons, it is closely rivalled by many other countries, notably France and America, and we hope that one result of the Congress will be to stimulate healthy rivalry.

Straw in the Streets.

IT is highly desirable in the interests of town-dwellers that some restriction should be placed upon the practice of laying down straw in the streets. Of course, everyone must sympathise with the sick folk for whose benefit the roadway is thus carpeted. At the same time the health interests of the neighbouring robust population must not be entirely overlooked. The straw, once laid down, is often left for weeks until it becomes a decayed, sodden and filthy mass of material, charged with the bowel organisms of the horse and with other undesirable pathogenic bacteria that infest the atmosphere of large cities. Who can measure the amount of potential mischief that lies in dust thus harboured and created? Clearly local authorities would be loth to interfere with the practice of straw-laying before the dwellings of sick folk, nor would the average citizen ask anything of the kind. It is quite another thing, however, to insist upon a renewal of the straw at intervals of a few days. Something of the kind is especially needed in the neighbourhood of Harley Street, where, owing to the presence of many private nursing homes the streets are sometimes covered with filthy straw for months together. There is something grotesque in the idea of a doctors' quarter being veneered with this wrapping of gratuitous and gruesome filth.

London Drinking Water and Cholera.

THE serious outbreak of cholera in Prussia reminds us that the dreaded disease in question can still find a foothold in many parts of Europe. But here, in the United Kingdom, we shall do well to look after our own house, or we may find out suddenly that we have been living in a Fool's Paradise. In 1848 no fewer than 53,000 persons died of cholera in England alone, and upwards of 20,000 in 1854. In 1855 and 1866 there were milder invasions, but the United Kingdom has since been practically free. The key to the situation is in the water-supply. Londoners were formerly supplied with unfiltered water taken in from the Thames at Battersea or Lambeth. A single case of cholera infecting the river above the intake sufficed to poison the metropolis. The intakes have been removed higher and higher up the river, but as the Thames water is still enormously polluted with sewage, there is always the chance of a cholera patient fouling the river above the point where it is tapped by the companies. Were that to happen, London would probably be decimated within a fortnight. Sand filtration, as practised in the companies' reservoirs, does not prevent the passage of cholera microbes. As urged by a speaker at the recent Health Congress in London :—" If Londoners are content to drink diluted sewage, let them at least insist upon having it sterilised by the companies before delivery to consumers."

Bacteriology of the Mouth.

THE investigation of the bacterial flora which inhabit the mouth under normal and pathological conditions is a matter of interest not only to the pathologist and dentist, but also to the clinical physician. It has been shown by more than one observer that the mucous membrane of the posterior parts of the nasal chambers under normal conditions is sterile, owing to the filtering action exerted in the air by the anterior parts of the same chambers; but, as would be expected, the conditions found in the mouth are very different, and constitute in consequence one of the many objections to the practice of mouth breathing. Almost all writers on the subject of mouth bacteria point out the fact that there are constantly to be found in that cavity not only putrefactive organisms and numbers of leptotrichinae, but also the pyogenic bacteria. A recent investigation of thirty healthy mouths by Dr. Livings, of Milwaukee, has emphasised the above facts, and has further demonstrated the occasional presence of the bacillus coli communis, an organism which has been found more than once in fine culture in the parotid abscesses that are liable to follow abdominal operations. This fact may prove of clinical importance, for it is not unlikely that the number of such abscesses would be diminished by the practice of thorough mouth asepsis, before and after abdominal operations, and also during the course of such diseases as appendicitis and typhoid fever. Another interesting fact established by Dr. Livings is that the mouth of a tobacco user contains many more germs, than that of an ordinary—or should we say extraordinary?—individual and that tobacco-juice exerted no restraining influence upon their growth. It is comforting, however, to the smoker to reflect that he is not really more exposed to infection than others, if he uses ordinary care in cleansing his teeth, as Dr. Livings attributes his results to the fact that tobacco users as a rule are not very careful in performing the toilet of their mouths.

PERSONAL.

The Earl of Mount-Edgcumbe last week opened a new wing of the Devon and Cornwall Sanatorium for Consumptives at Didworthy, Devon. The building has cost £800.

Professor William Osler, of Oxford, has accepted the post of Thomas Young Lecturer on Medicine at St. George's Hospital, and will give a series of lectures and demonstrations at the hospital next spring on the diagnosis of abdominal tumours.

Professor G. H. F. Nuttall, F.R.S., of Cambridge University, will deliver the opening address of the winter session of the London School of Tropical Medicine in the Lecture Theatre at the school on Wednesday, October 11, at three o'clock.

Major C. G. Spencer, R.A.M.C., has joined the Royal Army Medical College from the Curragh on appointment as Professor of Military Surgery in succession to Major-General W. F. Stevenson, C.B., retired. Lieutenant-Colonel Robert J. S. Simpson, C.M.G., R.A.M.C., to be Professor of Military Medicine, vice Lieutenant-Colonel K. McLeod, I.M.S., retired pay, who has vacated that appointment.

The late Sir Charles Cunliffe Smith has bequeathed £1,000 to the London Hospital, and the late Mr. E. C. Murray, of Dublin, has bequeathed £1,000 to the Royal City of Dublin Hospital to found two beds in memory of his family.

The Government has accredited Dr. C. Theodore Williams and Dr. H. T. Bulstrode as the British delegates to the International Congress on Tuberculosis, which will meet in Paris next month.

The will of Dr. John Willam Ogle, Vice-President of the Royal College of Physicians of London, and of the Royal Medical Chirurgical Society, whose death was recently announced in these columns, has been proven under probate at £30,701.

The new nurses' home at the London Hospital, providing accommodation for 260 nurses, will be ready for occupation in October, and the governors lately confirmed the recommendation of the committee to call the home after the matron, Miss Eva Luckes, "as a recognition of her twenty-five years' faithful service to the hospital."

To celebrate the twenty-first year of its existence and to perpetuate the memory of its founder, the late Dr. Norman Kerr, the Society for the Study of Inebriety, has determined to found a Norman Kerr Lectureship. The sum estimated to be required for its upkeep is £300. About one-third of this amount has already been received.

A copy of the original pamphlet by William Harvey on the "Discovery of the Circulation of the Blood, published 1628, fetched £30, at a sale of the collection of the late Dr. Thomas Pettigrew.

The Welsh national monument, in the form of a Celtic cross, to the late Professor Alfred Hughes, F.R.C.S., director of the Welsh hospital in the Boer War, who succumbed to fever, has just been unveiled at Corris, on the road leading to Cader Idris, and bears an inscription and a bust of the late professor, who, when a boy, worked in the Corris quarries.

Acting on a suggestion from the Duchess of Marlborough, a bazaar will be held at the Stratford Town Hall on October 26th, 27th, and 28th, 1905, in aid of the extension of the West Ham and East London Hospital.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

"Bile Beans" in the Law Court.—A curious and not uninteresting light was thrown on the nature of this much advertised and vaunted nostrum in the Court of Session the other day in Lord Ardwall's judgment in an action brought by the manufacturers of the remedy against an Edinburgh chemist to interdict him from using the name "Bile Beans" for any pills other than those manufactured by them. The history of "Bile Beans," as set forth in his Lordship's judgment, is as follows:—In 1896 the complainer, then only twenty-one years of age, was in business in Australia in connection with a stationery or printing business. He had no knowledge whatever of chemistry or medicine, but happened to get introduced to the other complainer, Charles Fulford, who, though not a qualified chemist, had served five years in a chemist's shop, and had been connected with the business of a medicine company. The two complainers went into partnership to carry on business as pill manufacturers, and first started the preparation of Gould's Tiny Tonic Pills, which, however, did not meet with the success anticipated. In the early part of November, 1899, Fulford told his partner that at four o'clock in the morning he had hit upon a title for a new pill, namely, "Bile Beans for Biliousness," and he prescribed a formula for it. The pill took in Australia, and Fulford proceeded to put it on the English market. Neither the company nor the partners manufactured the pills. Even their name was misleading. They merely sent the formula to manufacturing chemists to make the pill in millions. They advertised on an extensive scale, spending £300,000 in building up the business in the United Kingdom, and issuing eighty-three millions of small illustrated pamphlets for house-to-house distribution, as well as a large number of musical advertisements. If one might judge from the way in which it was perpetually set forth in the forefront of their advertisements, the foundation-stone of their success was the false and fraudulent statement that Bile Beans were for the most part composed of a natural vegetable substance which Fulford discovered in Australia, which for ages had brought health and vigour to the natives of that island continent, and which was now being introduced for the benefit of civilised nations. One of the latest advertisements was entitled "Strange Japanese Customs," in which it was said, "Some years back Charles Forde, an eminent scientist, thoroughly investigated the healing extracts and essences of Australian roots and herbs, and after long research he found himself the discoverer of a natural vegetable substance which had the power of acting in the human system in the same way as Nature's own animal substance bile, and which was beyond all doubt the finest remedy yet discovered for all liver and digestive disorders." This statement, said his Lordship, was both false and fraudulent. There was no such person as Charles Forde, his true name being Fulford; he was not an eminent scientist, having had no scientific training and no standing whatever as a chemist or anything else; he never investigated the healing extracts and essences of Australian roots and herbs; he never made any research; he never was the discoverer of a natural vegetable substance which acted like animal bile. In fact, no such substance existed, and no such substance formed the part of Bile Beans, which were compounded by wholesale chemists in America out of drugs which they had in stock, no one of which had anything specially to do with Australia. The changes were rung on this wonderful discovery in every pamphlet and advertisement of the complainers'. His Lordship had no doubt that their business was founded entirely on fraud, impudence, and advertisement, though it might be that the pill was as effective as any ordinary pill so compounded to act as a cholagogue or ordinary laxative medicine; but it seemed certain that these beans would never have taken hold of the public as they had done except for the foundation fiction of their being the product of a Great Discovery of an Ancient Australian Medicine by an Eminent Scientist using the most Advanced Scientific Methods and Apparatus. Lord Ardwall was of opinion that these frauds constituted relevant ground for refusing the complainers the remedy they sought. The case of Forde *v.* Foster was founded on by the complainers as showing that collateral misrepresentation regarding a trade name did not disentitle the owner of the name to relief at law, but it seemed to his Lordship that the name of Charles Forde and all the fraudulent statements regarding him and his discovery were indissolubly connected with the term "Bile Beans" as used by the complainers, and that the Court was bound to take notice of the fact that the complainers' trade, in connection with which the name "Charles Forde's Bile Beans" was used, was a fraudulent trade. On these grounds he refused the application. To exhaust the case, and dealing with the other points raised as if the complainers' trade were untainted by fraud, his Lordship held that it had not been proved by the complainers that the term "Bile Beans" was a fancy name of their invention, nor had they established such a right to it as to preclude the use of the words by other sellers of oval pills for biliousness. Further comment on the proceedings of Messrs. Gilbert and Fulford is unnecessary. To the average man Lord Ardwall's decision will seem full of that common-sense for which his Lordship has always been noted, and on account of which his recent elevation to the Bench was hailed with so much satisfaction in legal circles.

Chair of Midwifery, Edinburgh University.—The following is the list of candidates for the chair:—Drs. J. W. Ballantyne, A. H. Freeland-Barbour, James Haig Ferguson, D. Berry Hart, F. W. N. Haultain, W. E. Fothergill and Sir Halliday Croom. With the exception of Dr. Fothergill all are local men. The curators will meet on October 2, to consider the applications.

BELFAST.

Belfast Lunatic Asylum: Dr. Graham's Annual Report.—This report, dealing with the year 1904, has just appeared, and contains much matter of interest. The average number of inmates of the asylum was about 1,050, with nearly equal numbers of males and females. The admissions were 266, the discharges 154, and the deaths 100, the net increase in the number of patients being 12. Dr. Graham calls attention to the low recovery rate and the high death rate, which he attributes to the large number of senile cases sent from the workhouse. Though no means are provided in the workhouse for the proper care of these cases, the asylum hardly seems the proper place for them, and there can be little doubt that Dr. Graham is right in his contention that the presence of these cases in the asylum, and also the idiots and imbeciles, prevents the insane from receiving the benefit they might otherwise derive from asylum treatment. The cost of provisions was £7 12s. 2d. per head per annum, and the total cost was £21 4s. per head. Of this latter, £11 4s. 7d. falls on the city for each patient chargeable to the rates, the balance being paid by the Government grant, profits of the farm, etc. Sir George Plunkett O'Farrell, M.D., inspected the asylum in December last, and his report is appended. In it he says: "As so little original research is carried on in Ireland, and indeed, it may be added, there is so little opportunity for it in Irish asylums, it must be gratifying to the Committee to know that pathological investigations, which promise to be of permanent value in the study of insanity, have been carried on in their laboratory by Dr. R. A. L. Graham, assistant medical officer."

Children's Infirmary at the Belfast Workhouse.—The accommodation for sick children at the Belfast Workhouse was discussed by the guardians last week, on receiving the recommendation of a committee that a new children's Infirmary to accommodate 250 patients should be built. The discussion, as is so often the case, degenerated into an unseemly wrangle, in which two medical members of the board took active and opposite parts, but there seems little doubt that further accommodation is urgently required, and will shortly be provided.

Dunlop Memorial Home, Holywood.—About three years ago, Dr. Archibald Dunlop passed away, after nearly fifty years of medical practice in Holywood. There was no more familiar figure in the country round, and no more universal favourite alike with men, women, and children. It is not surprising, therefore, that a movement to erect some permanent memorial to him should have been warmly supported, and the outcome of this movement is seen in the Memorial Home opened last week. The building stands in its own grounds on an excellent elevated site in Church Street, Holywood. It is of red brick below and rough-cast above, with red tiled roof. It is designed to form first a home and centre of work for the two district nurses of the place, but it is to some extent a cottage hospital also, as there are children's and emergency wards for use when necessary. The Home has been opened free of debt, with a small endowment fund to help it. It will no doubt prove a most useful aid to the local medical men in their work among the poor of the district.

Outbreak of Typhus in County Donegal.—A severe outbreak of typhus is reported from Clonmany, in the Inishowen Peninsula, the extreme northern point of Ireland. Whole families have been taken ill, and conveyed to the fever hospital at Carndonagh, the centre of the district. Five have died, including the fever nurse and two wards women. Great regret is expressed at the death of the nurse, Miss Agnes McGinnis, a niece of Dr. Sigerson, of Dublin, specially as her sister, who had preceded her in the hospital, had also died in the discharge of her duty. It is doubtful how the fever originated, but there is not much doubt as to how it is propagated if the statement made and reiterated by one of the guardians at a board meeting is correct, namely, that he had that day seen a woman from a fever-stricken house selling wool and butter in the market at Carndonagh!

The annual meeting and dinner of the Association of Public Vaccinators of England and Wales will be held at the Midland Hotel, Manchester, on Friday, October 27th.

Correspondence.

"NORMAN KERR" LECTURESHIP.

To the Editor of The Medical Press and Circular.

Sir,—Twenty-one years ago the late Dr. Norman Kerr founded the Society for the Study of Inebriety. It has been thought by many of his old friends that the coming of age of the Society would afford a fitting opportunity to perpetuate his memory. The Council have therefore decided to found in connection with the Society, and in recognition of his enduring work in relation to the Study of Inebriety, a "Norman Kerr" Lectureship. It is believed that many well-known persons would be ready to deliver such a lecture before the Society, both in honour of the founder thereof and for the furtherance of the investigations that he so ably inaugurated. It has also been suggested that a sum of £300 should be raised to form a fund, the interest of which should be available for the purposes of the lectureship. Towards this amount nearly £100 has already been promised. We feel sure that these proposals will meet with the approval of all the Members and Associates of the Society, and with others who knew Dr. Norman Kerr. All contributions towards the special "Norman Kerr Lectureship Fund" should be sent to the Hon. Treasurer of the same, Mr. McAdam Eccles, 124, Harley Street, W.

We are, Sir, yours faithfully,
Harry Campbell, *President.*
W. McAdam Eccles, *Hon. Treas. Special Fund.*
T. N. Kelynack, *Hon. Sec.*
September 16th, 1905.

Obituary.

SURGEON-GENERAL WILLIAM McCONAGHY, R.A.M.C.

Surgeon-General William McConaghy, whose death was announced recently, was born in 1845, and entered the Indian Medical Service in 1869. He served with the 26th Regiment, Bombay Infantry, until September, 1877, when he was appointed superintendent and magistrate of the hill station of Matheran. In 1878 he obtained a similar appointment at the more important hill station of Mahableshwar. On leaving Mahableshwar in September, 1882, he received the thanks of the Government for the good work done by him there, and he then served as civil surgeon and superintendent of the prison at Dharwar for more than nine years. In 1892 he became civil surgeon at Poona, superintendent of the Medical School, where he lectured on medicine and therapeutics, and superintendent of the lunatic asylum. He was also in medical charge of the Deccan College. In 1897 he was appointed principal medical officer in Sind, and in 1902 he obtained the highest appointment open to the medical service in the Presidency, that of Surgeon-General with the Government of Bombay. Serious illness compelled him to resign this post early in the present year. Surgeon-General McConaghy married a daughter of the late General Christopher Birdwood, of the Bombay Army.

Dr. WALTER DYMOCK PERRY.

The news has been cabled to this country of the death in Johore, Straits Settlements, of Dr. Walter Dymock Perry, who practised for some two or three years at Cardiff and Penrhiwceiber. Death was the result of a carriage accident. The deceased, after leaving Cardiff in 1902, accepted an appointment at a British Government Hospital in Borneo, and afterwards became medical adviser to the household of the Sultan of Johore. His widow and child reside in Glasgow.

MR. THOS. CHRISTY, F.L.S., F.R.G.S.

The death is announced of this gentleman, who, although not a medical man, has been closely allied to the profession of medicine during a long and strenuous life. In association with the Hanburys he was engaged more than fifty years ago in botanical research in the Far East, devoting particular attention to medicinal plants and substances and their production, and through his instrumentality, many new and rare drugs were introduced to the notice of the medical profession in this country. Mr. Christy was an enthusiastic botanist, and almost to the time of his death rejoiced in the cultivation of rare medicinal plants in his own private garden at Wallington. He was a member of the Linnean Society, and joint author with Dr. A. C. Leonard, of the well-known "Dictionary of Materia Medica and Therapeutics."

MR. JOHN HALL, M.R.C.S. ENG., L.S.A., SHEFFIELD.

We regret to announce the death of Dr. John Hall, of Sheffield. He had been in failing health for some time, and died at his residence on the 10th inst. at the age of 77. Born at Greasborough, near Rotherham, in 1828, he was the third son of the late Rev. Francis Hall, who for twenty-four years was Vicar of Greasborough. Dr. John Hall was educated at Christ's Hospital, London, after which he was a student at the Sheffield School of Medicine, from whence he became qualified M.R.C.S. in 1854, and was appointed house surgeon at the Sheffield General Infirmary, now the Royal Infirmary. He remained at that institution for ten years, when he entered into partnership with the late Mr. Edward Martin. For many years he held the position of surgeon to the Sheffield Post Office.

JOSEPH GREASLEY, M.R.C.S., Eng, L.R.C.P. and S., Edin.

We regret to record the death of Dr. Greasley, M.R.C.S., Eng., L.R.C.P. and S., Edin., who died at his residence last week. He took his three degrees in 1877, and was known in Leicester as a clever doctor and good friend. For many years he had been hon. medical adviser and attendant to the blind people in the town and at the Wycliffe Cottage Homes for the Blind. His readiness to respond to every call had been altogether exceptional, his generosity and kindness in this direction knew no bounds. A resolution of condolence with the widow was passed, and a wreath sent to the funeral on behalf of the blind people of Leicester.

ARTHUR ATKINSON JACKSON, M.R.C.S., Eng.

The town of Smethwick is the poorer for the loss of Dr. Arthur Atkinson Jackson, brother of Dr. W. F. Marsh Jackson, the medical officer of health for the borough, which occurred at Hagley. The deceased gentleman was the son of the Rev. W. Jackson, vicar of Adbaston, Salop, and practised as a surgeon in partnership with his brother for many years at Smethwick. He graduated M.R.C.S. in 1879. He had been in failing health for some time. The deceased gentleman took a deep interest in local affairs, and was also closely connected with numerous charitable and social movements in the town.

PHILIP BROKE SMITH, M.D.

Surgeon-Major-General Philip Broke Smith, M.D., late of the Army Medical Staff, died recently at Cheltenham at the age of 71. He was the third son of Captain William Smith, R.N., of Berwick-on-Tweed, who, as a midshipman, was the first to board the American ship "Chesapeake," by the yardarm, in the famous battle between the "Shannon" and the "Chesapeake" in 1813. He was admitted a licentiate of the Royal College of Surgeons, Edinburgh, in 1856, took the M.D. degree in 1857, and joined the medical service of the Army in the latter year. He served for some time with the 87th Regiment (Royal Irish Fusiliers). His last appointment was that of Principal Medical Officer at Netley, where he had charge of the Royal Victoria Hospital, and he retired from the Army in 1894 as Surgeon-Major-General.

Literature.

TAYLOR'S SANITARY INSPECTORS' HANDBOOK. (*a*)

THIS, the fourth edition of a well-known handbook, presents in complete form the features that have established the value of former editions. The book is indispensable to sanitary inspectors who take their work seriously, and who aim at sound knowledge, as well as a rule-of-thumb administrative facility. The somewhat difficult subject of meat inspection is dealt with in detail sufficient for market inspection. The student of this part of the book will gain a good insight into the scope of that particular branch from the ample list of examination questions dealing with meat inspection.

DOCKRELL'S ATLAS OF DERMATOLOGY. (*b*)

THE present may be called an age of Atlases. Among those devoted to Dermatology, the one now contributed by Dr. Morgan Dockrell may claim an element of originality in its method of arrangement. The author has taken typical examples of forty-six diseases of the skin and has illustrated each by an excellent coloured photograph, beneath which is a beautifully executed illustration of the microscopical appearances. In this way a full opportunity is afforded of associating the clinical with the underlying pathological conditions. On the opposite page is a short note of the points to be looked for in the illustration. There is no attempt at detailed description of anything beyond the limits as above set forth. Of the excellent nature of the work contained in this atlas there can be no doubt. Many of the clinical illustrations reach the highest level attainable. They carry the conviction always attached to a real likeness and are sufficiently graphic to dwell in the memory of those who consult these either for reference or for educational purposes. Although we may not in all detail agree with the author, yet on the whole we accept the accuracy of his views. The microscopical illustration of alopecia areata may be taken as a type of that part of the work. The drawings are from a section stained with hämatoein and neutral orcëin. The brush-like splitting and pigmentation of the affected hairs broken off level with the epidermis, the atrophy of hair root, hair shaft in follicle, and the invasion of the latter by bacilli with other pathological points are excellently shown. The descriptive text is in the form of terse and severely restricted explanatory notes. This book registers some good work in English dermatology.

CLINICAL STUDIES IN SYPHILIS. (*c*)

IN spite of its title, this interesting little work contains a large proportion of theory, since it is based on what the author calls the microbe-toxin theory which, although not proved, is stated by Mr. Ward to be very generally accepted. It must be taken into consideration, however, that Mr. Ward's theories, as theories, are put forward in a very ingenious way, especially with regard to the supposed syphilitic microbe generating the syphilitic toxin, the former remaining fixed whilst the latter is diffused into the circulation, Colles's law being thus explained. In his description of the initial lesion, we think the author lays too much stress on the question of induration, and also that he gives a somewhat erroneous impression in speaking of the primary sore in its second stage as being a. . . worm-eaten ulcer; we think also that Mr. Ward generalises too much in saying that during the secondary latent period "the primary sore tends to grow larger, more indurated, and more callous," as in the majority of cases, according to general experience, the primary sore is a most insignificant lesion, healing readily and giving no trouble, as, for instance, in women in whom it is even rare to see more than slight traces of the primary lesion, so little inconvenience has it caused. The portion of this work devoted to treatment is well worthy of perusal by any medical men as being the outcome of practical experience.

FIRST AID. (*a*)

"FIRST AID" has become such a popular subject that we are not surprised that this little book, although not the official text-book of either the St. John's or St. Andrew's Ambulance Associations, has reached its fourteenth thousand. The anatomical and physiological introduction, reaching as it does to 64 pages, is rather more elaborate than is necessary for the lay audiences to whom this book appeals; whilst the question that does, or should, interest them, namely the diagnosis of injuries, is glossed over too superficially. On the other hand the diagrams which form such an important feature in a work of this kind are admirably clear, and we note with pleasure that Drs. Warwick and Tunstall do not recommend indiscriminate cauterisation of people who have been bitten by dogs. This "method of barbarism" still persists, we believe, in official text-books of the St. John's Ambulance Association. We can heartily recommend this little work to lecturers on First Aid as a framework for their course.

INTERNATIONAL CLINICS. (*b*)

Volume I. of the Fifteenth Series of International Clinics contains, in addition to some interesting papers and some indifferent material, an unusually good summary of the progress of therapeutics, medicine and surgery during the year 1904. This summary occupies about one-third of a volume of 308 pages, and is throughout exceptionally well done, but the most striking part of it and of the whole volume is the section devoted to surgery, which is written, rather than compiled, by Dr. Bloodgood, of the Johns Hopkins Hospital. We do not recollect having ever read under this guise anything so interesting and refreshing, and we believe that editors of similar works would be well advised to taken the hint here offered to them, and urge their contributors to give their own opinions and their own experience concerning the subjects with which they deal, instead of being satisfied by making a sort of dictionary *precis* of the year's literature.

As an example of Dr. Bloodgood's method, we may quote a few of his remarks. In his introduction he points out that "Surgical technique is in advance of surgical diagnosis," a fact which we believe to be incontestable, and throughout his article he lays special stress upon those papers which deal with diagnosis and surgical science rather than with those which deal with operative measures. The sooner that this statement is fully appreciated the better, for unfortunately the "make a diagnosis-at operation" surgery is even more prevalent to-day than when Erichson wrote the well-known opening paragraphs of his text-book, and constitutes a danger not only to progress, but also to life. Again, speaking of the treatment of fractures, the writer says: "If I were asked to criticise the usual methods I would say: 'A lack of exact diagnosis; too permanent and too tight fixation dressings. The general public must be educated to the fact that the majority of fractures require frequent dressing, and that the parts in the neighbourhood of the fracture should have massage, and the joint passive motion.'" He then goes on to illustrate the above by quotations and by the records of actual cases, and proves most satisfactorily that the rigid plaster method recently adopted and praised

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(*a*) "Sanitary Inspectors' Handbook." By Albert Taylor. 4th Edition. London: H. K. Lewis, 1905. Price 6s.

(*b*) "An Atlas of Dermatology." By Morgan Dockrell, M.D Dub. Senior Physician St. John's Hospital for Diseases of the Skin. London: Longman, Green. 1905.

(*c*) "Clinical Studies in Syphilis." By Arthur H. Ward, F.R.C.S. Pp. 156. *Medical Times*, Limited.

(*a* "First Aid to the Injured and Sick. An Ambulance Handbook By F. J. Warwick, B.A., M.B. Camb., M.R.C.S. L.S.A.; and A. C. Tunstall, M.D., F.R.C.S.Ed. Third and Revised Edition. Bristol: John Wright and Co. 1905. 1s. net.

(*b*) "International Clinics." Vol. I. Fifteenth Series, 19
Philadelphia and London: J. B. Lippincott & Co.

by so many surgeons is both inefficient and unscientific. Dealing with tumours, and especially with sarcomas of bone, he says: "It appears to me that, if a mistake is to be made, it is better to err in favour of a less extensive operation. The patient suffering with a sarcoma of a low grade of malignancy will be saved, while the one who has the misfortune to have the most malignant form of sarcoma will not die any quicker." This conclusion is, perhaps, open to question, but as the result of wide experience is one worth having in mind. Many other interesting points might be referred to, but enough has been said to show the general tenour of the article which by itself is quite sufficient to make the book worth purchasing.

Laboratory Notes.

KUMA.

We have examined this new antiseptic preparation (prepared by the Cosmo Chemical Co., Ltd., 62, Farringdon Street, E.C.), which is described as "a general antiseptic especially intended for use in the mouth." We find it to be a judicious blending of certain essential oils of unquestionable bactericidal power, together with other constituents, the whole forming a combination admirably adapted to serve as a mouth wash both as regards antiseptic properties and also to act as a deodorant in cases of foul breath. Diluted in the manner recommended, it provides a mouth wash, soothing, antiseptic, and pleasant to use. The analytical data are most satisfactory—the total solids being 0·77 and the ash being 0·032 grammes per 100 cubic centimetres—showing the constituents to be almost entirely of a volatile nature. It is in our opinion admirably adapted for the purposes of a mouth-wash, and although a few people would object to the sensation peculiar to preparations containing oleum menthæ piperita in the mouth, we are sure that the great majority of users will appreciate its merits.

WRIGHT'S COAL TAR SOAP.

This well-known soap has now been before the medical profession and the public for more than forty years. When it was first introduced, the recommendation of the profession at once brought it into prominence as the soap best suited for use in the case of young children, on account of its marked antiseptic qualities and the fact that it does not irritate the skin of the youngest infant.

Improvements have been made from time to time and the soap is now a milled one—the softest and most pleasant to use. We find on analysis that the melting point of the fatty acids is high, being from 43° to 44° C., and the soap appears to be superfatted with lanoline. We have not found any trace of resin, nor is any artificial colouring matter present except of vegetable origin. The soap undoubtedly fulfils the claim of being a true antiseptic one, and is suited to the most sensitive skins—even those of babies from birth. The actual tar-bodies contained in it, prepared from *liquor carbonis detergens*, are of a complex character. On analysis we find the tar-bodies amount to a little over 5 per cent., and consist principally of cresylic acid. Combined as they are they exert an antiseptic action equal to a soap containing 15 per cent. of pure phenol, but without its irritating effect.

In these days of cheap soap containing resin and silicates, made from fats of doubtful origin, and coloured in some cases with objectionable dyes, it is important to point out that for the tender skin of children only a standard article like Wright's Soap should be employed, and as almost all makers of soaps claim antiseptic properties whether they exist or not, the knowledge of a standard soap possessing *uniform* antiseptic value and at the same time pleasant and freefrom any irritative properties, cannot be too widely spread.

Soaps containing free soda are doubtless suitable for washing clothes and rough work, but a different article is needed for the delicate skin of children and Wright's Coal Tar Soap is, in our opinion, an ideal soap for nursery use.

Medical News

The Norman Kerr Memorial Lecture.

The first Norman Kerr Memorial Lecture of the Society for the Study of Inebriety, will be delivered by Dr. T. D. Crothers, Professor of Mental and Nervous Diseases in the New York School of Clinical Medicine, Secretary of the American Medical Society for the Study of Alcohol and Narcotics, and editor of the American *Quarterly Journal of Inebriety*, on Tuesday, October 10th, at 8.30 p.m., in the rooms of the Royal Medical and Chirurgical Society of London. The lecture will be preceded by a reception by the President of the Society for the Study of Inebriety, Dr. Harry Campbell, and its Council, and will be followed by a conversazione. It is greatly desired that a large and representative meeting should assemble to welcome and hear Dr. T. D. Crothers, whose researches into the pathology and treatment of inebriety are so well-known. Admission will be by ticket only, which may be obtained on application to Dr. T. N. Kelynack, Hon. Secretary of the Society for the Study of Inebriety, 120, Harley Street, London, W.

Royal Academy of Medicine.

The annual general meeting of the Royal Academy of Medicine in Ireland will be held in the Royal College of Surgeons on Friday, October 13th, 1905, at 4.30 p.m., when the Report will be submitted and the election of officers will take place. Nominations of candidates for office, whose sanction has been obtained, must be sent to the General Secretary in writing not later than Tuesday, October 3rd. The offices for which candidates may be nominated are—General secretary and treasurer; secretary for foreign correspondence; member of council in the sections of medicine, surgery, obstetrics, pathology, anatomy and physiology, and State medicine.

Belgian Congress of Neurology and Psychiatry.

The first Belgian Congress of Neurology and Psychiatry will be held at Liège on September 28th, 29th, and 30th, under the patronage of the Government and the Honorary Presidency of the Ministers of Justice and Agriculture. Among the questions to be discussed are the following: (1) Work considered as a therapeutic agent; (2) lumbar puncture from the diagnostic and therapeutic points of view; (3) the sense of pain. Visits will be paid to the principal university establishments and to the lunatic asylums of the district. The General Secretary is Dr. Massaut, 19, Boulevard Defontaine, Charleroi.

Prize Competition for the Prevention of Lead Poisoning.

The International Association for Labour Legislation is prepared to offer a prize of £250 for the best treatise on the prevention of lead-poisoning in mining and milling lead ores; £500 for the best treatise on the prevention of lead-poisoning in smelting and refining works; two prizes (1) £125, (2) £75, for similar treatises relating to white-lead works, paint works, manufacture of electrical accumulators, &c.; four prizes (1) £75, (2) £50, (3 and 4), £37 10s. each, for house, ship, and coach painting, &c.; and four prizes ranging from £75 to £37 10s. for the best treatise on the prevention of lead-poisoning in trades where raw and manufactured lead are consumed or handled, as in type foundries and printing offices. The essays must be sent in to the International Association for Labour Legislation, Basle, Switzerland, not later than May 15th, 1906. Leaflets giving full details can be had by applying to the Honorary Secretary, British Association for Labour Legislation, Club Union Buildings, Clerkenwell Road, London, E.C.

As soon as the vacation season is ended, the members of the Medical Society of London will be called together to discuss the proposal of amalgamation between the Royal Medical and Chirurgical Society and the Royal Medical Society, and upon the decision of this meeting practically depends the adoption or rejection of the scheme.

Notices to Correspondents, &c.

☛ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," 'Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

Dr. H. (Anerley).—Apomorphin has been used successfully in Chorea. 1-40th of a grain hypodermically administered will often bring repose and sleep.

Dr. F. (Cardiff).—The taking of lead as an Abortifacient is comparatively recent. One of the commonest forms is in the shape of largely advertised "female pills." It has been shown that if taken as directed 1-250th grain of lead, would be ingested daily.

AN IMPATIENT PATIENT.

A patient knocked at a dentist's door,
Who had slept little the night before,
The pain was so great he was ready to roar,
The dentist compelted him to sit near the floor.
With drilling machine he commenced to bore,
Till the nerve was touched up, when awfully sore.
The patient refused to stand any more.
It is sometimes unpleasant to tell the truth,
He lost that patient, but saved the tooth.—A.D.

A Member of the Society.—The person referred to was never a member, nor even a registered chemist. We have always understood that his object in turning his business into a joint stock concern was to secure him from threatened prosecution by the Pharmaceutical Society.

Third Year.—We have looked through the new edition of Rose and Carless' "Manual of Surgery" just to hand and find the revision has made it the most complete work on the subject with which we are acquainted.

Dr. F. (Stirling).—The best account of Phlegmasia Alba is in Quain's *Dictionary of Medicine* in an article by Matthews Duncan, revised by Gervis.

Analyst.—Strophanthus often succeeds when digitalis has failed, the former being more powerful and more quickly absorbed into the system.

Inspector.—(i) Professor Oliver's lecture on *Anklostomiasis* can be had from Williams and Norgate, London, Price 1s. (ii) Factory Surgeons are appointed by H.M. Chief Inspector of Factories, Home Office, S.W. Vacancies are advertised in the *Gazette*.

Police Court Reform.—It has been suggested that a Board of Commissioners consisting of one barrister and two medical men should appointed to administer an Act dealing with the Care and Control of the Feeble Minded.

AN IMPROVED RECTAL SPECULUM.

A Correspondent writes: "The Rectal Speculum pictured and described in Medical Press of Sept. 6th, as suggested by Sir Lambert Ormsby is an exact enlarged copy of Aural speculum, already on the market (minus plug), and certainly not original in design. The same idea is carried out both in aural and vaginal speculæ and pictured in various surgical instrument catalogues."

Colonial.—The proposal at the S. African Medical Congress to found a South African Medical Guild fell through, but it is believed it will be carried out through private enterprise.

Medico-Legal.—Deferred apoplexy after an accident is not uncommon; in fact, may occur four days after the injury. The point is of importance with regard to compensation.

Operator.—There is no objection to the use of black pins. In fact they are better as they do not rust and can easily be seen in surgical dressings.

Meetings of the Societies, Lectures, &c.

Wednesday, September 20th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. T. P. Legg: Clinique. (Surgical.)

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—3 p.m. Mr. Bidwell: Intestinal Surgery.

Thursday, September 21st.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.)

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—2 p.m. Dr. Arthur: Skiagraphy.

Friday, September 22nd.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Dr. J. Horne: Clinique. (Throat.)

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—10 a.m. Dr. Shuter: Anæsthetics. 4.30 p.m. Mr. Bidwell: Intestinal Surgery.

Vacancies.

City of Liverpool.—Fazakerley Hospital for Infectious Diseases.—Medical Superintendent. Salary £400 per annum, with house, coal and lighting. Applications to the Town Clerk, Municipal Offices Liverpool.

Leyton, Walthamstow and Wanstead Children's and General Hospital Orford Road, Walthamstow.—House Surgeon. Salary £100 per annum, with rooms, board, &c. Applications to the Secretary.

Kent County Ophthalmic Hospital, Maidstone.—House Surgeon. Salary £100 per annum, with board, to reside in the Hospital. Applications to the Secretary.

Salisbury General Infirmary.—House Surgeon. Salary £100 per annum, with apartments, board and lodging. Applications to the Secretary.

Corporation of Sheffield.—Fever Hospitals.—Second Assistant Medical Officer. Salary £100 per annum, with board, lodging and washing. Applications to H. Sayer, Town Clerk, Town Clerk's Office Town Hall, Sheffield.

Wolverhampton and Staffordshire General Hospital.—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to Edmund Forster, House Governor and Secretary, Wolverhampton.

Royal London Ophthalmic Hospital (Moorfields, Eye Hospital), City Road, E.C.—Senior House Surgeon. Salary £100 per annum, with board and residence. Applications to the Secretary.

Waterford County and City Infirmary.—House Surgeon. Salary £100 per annum, with board, &c. Applications to the Secretary. (See Advt.)

Appointments.

Barker, Frederic, M.R.C.S.Eng., L.R.C.P.Lond., Resident Medical Officer at the Hospital for Epilepsy and Paralysis, Maida Vale, London, W.

De Pinna, Herbert Alfred, M.R.C.S.Eng., L.R.C.P.Lond., L.D.S. Eng., D.D.S.Ontario Medical Officer (Ship's Surgeon) to the Peninsular and Oriental Steam Navigation Company.

Duncan, Alexander, M.B., C.M.Glasgow, D.P.H.Cantab., Medical Officer of Health of Merthyr Tydvil.

Eades, Albert Irwin, L.R.C.P., L.R.C.S.Irel., Medical Superintendent of the North Riding Asylum, at Clifton, Yorkshire.

Gittins, Alfred B., M.R.C.S.Eng., L.R.C.P.Lond., Temporary Medical Officer of part of the Whitmore District of the Newcastle Union, Staffordshire.

Mouat, Janet A. S., M.B., Ch.B.Edin., Resident Medical Officer at the Potteries Joint Hospital, Bucknall, Staffordshire.

O'Meehan, P., L.D.S., R.C.S.I., Honorary Consulting Dental Surgeon to St. John's Hospital, Limerick.

Births.

Main.—On September 14th, at Brook House, Bollington, Cheshire, the wife of D. W. Main, M.B., of a son.

Williamson.—On September 12th, at Blaby, Leicester, wife of Lt.-Col. J. G. Williamson, Royal Army Medical Corps (Ret.), of a daughter.

Marriages.

Pearse—Dobbs.—On September 14th, at the Parish Church, Greystones, Surgeon-Major Albert Pearse, R.A.M.C., second son of Colonel C. J. Pearse, Madras Staff Corps, to Jennie Margaret, second daughter of R. Cathcart Dobbs, Esq., J.P., Knockdolian, Greystones, co. Wicklow.

Deaths.

Hutchinson.—On September 14th, at Rawcroft, Combe Park, Bath Roseanne, the wife of Charles W. Hutchinson, and eldest daughter of the late James Adams, M.D., of Glasgow.

LOCUM TENENS.—A gentleman, doubly qualified and with considerable experience of general practice, wishes to obtain a post in London or the provinces as LOCUM TENENS, or to assist a practitioner unable to compass his daily work to the full. The most satisfactory references possible. Address, in first instance, Locum Tenens, c/o Messrs. Bailliere, Tindall & Cox, 8 Henrietta Street, Strand, London.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, SEPTEMBER 27, 1905. No. 13.

Original Communications.

THE TREATMENT OF PERITONITIS.

By P. L. FRIEDRICH,

Professor der Chirurgie, Director der Kgl. chirurgischen Universitäts Klinik, Griefswald. (a)

THE variety of notions of individual authors with regard to the susceptibility of the peritoneum to infection is the best proof that unanimity of opinion regarding the infection process has not yet been attained. This circumstance has hitherto rendered it difficult to arrive at an agreement regarding the treatment to be adopted in dealing with peritonitis. It results that a general discussion can be carried on only with greater difficulty when we undertake a criticism of the treatment of peritonitis from the standpoint of a general view, and not from that of the variety of forms which may be sharply differentiated according to the source of origin of the peritonitis.

Accordingly, in all considerations regarding peritonitis, the most conspicuous position must be given to the fact that the origin of the peritoneal infection is an item of crucial importance. Accessible as is peritonitis of appendicular origin to our therapeutic procedures, we are to a corresponding degree impotent in presence of most cases of operative infection of that membrane.

Our procedure will be wholly dependent on the following conditions :—

1. At what stage of the disease we are consulted for the diagnosis and treatment of a case of peritonitis, and what is the state of the course of the absorption process in the abdominal cavity. Have we been summoned in the stage of unlimited or of languishing absorption ?

2. Are the anti-bacterial weapons of the organism still in an effective state, or have their powers been exhausted ?

3. Have the secondary phenomena which supervene upon paralysis or compression of the intestinal wall already assumed preponderance in the local symptom-group of the disease ?

Unprejudiced observation enlightens us with regard to most of these questions in each individual case, and with progressively increasing confidence when we possess clear views regarding the physiological processes which play special parts during infection. The peritoneum, more or less mechanically altered, receives at the seat of the lesion—wound, or whatever it may be—contact (or inundation) with almost unlimited bacterial infective matter, and accordingly capable of independent progressive development. Consequent upon the simultaneous emergence of other substances of mechanical or fermentative powers (toxic products of the bacteria themselves) may arise an immediate alteration of the epithelium of the serous surface which leads to rapidly-formed adhesion of the surfaces, and complicates the case with all the further alarming symptoms of adhesions and fixations. Or the bacterial dissemination spreads rapidly over a large section or the whole of the peritoneal surface, and thereby produces the clinical picture of an *unlimited, free,* but seldom, in the anatomical sense, entirely diffuse, peritonitis. As in normal physiological conditions, the play of absorption and of entrance of fluid into the peritoneal cavity always maintain an equal balance, so do these two factors influence in the highest degree the mechanism of defence and attack on behalf of the organism. Since the classic researches of Recklinghausen, and through the further experimental pursuit of these processes, we have become so far enlightened on the subject of the processes of absorption that we can say with certainty that after a period of active absorption of infective and inflammatory products, there follows a stage of retrogression of the process. The various foreign matters—partly living, partly dead—which are sucked up from the peritoneal cavity in the primary stage of absorption, lead directly to stimulation of the vaso-motor centre ; the consequence is that the continuation of the process of absorption leads to paralysis of that centre. These central processes lead to the following phenomena in the peritoneal cavity. In the stage of stimulation a contraction of the arterial vessels appears ; this must, in its turn, lower the co-efficient of absorption per unit of time in the peritoneal cavity. Accordingly we have presented to us the picture of a regulating apparatus on a large scale, the mechanism of which proves effective so long as no renewal of the poison-production, and no repetition of the lesion produced on the vascular innervation in regard to the range and efficacy of its function takes place from further poison-absorption. We cannot help recognising in the subsidence of the peritoneal absorption to the standard of previous normal, a curative agency of the organism ; and it should be inquired how far this healing process may be reinforced, and the life-endangering vaso-motor paralysis counteracted. When the latter has arrived at a pronounced stage of development, which finds its expression in the paralysis of the functions of the splanchnicus, and the excessive vascularity of the abdomen, the failure of the heart's action, the feebleness of the pulse, and the coldness of the extremities—then is the defective cardiac circulation and the general bleeding of the organism into the abdominal cavity hard indeed to counteract.

(a) Read before the International Surgical Congress, Brussels, September 19th, 1905.

When the stage of retarded absorption has been, spontaneously or by artificial influence, lengthened out, certain chemical cell-agents (antitoxin, leucocytin, "alexin," &c.)—in man, and demonstrably in the lower animals—come into play, entering the main battlefield, the peritoneal cavity itself, with the object of mastering the infection. We do not yet know the precise values of those agents in the process, nor the bactericidal results which the exudate collected in the peritoneal cavity effects by the action of the leucocytes; it is only that observation and experiment teach us this much, that in a great number of cases of the disease, with the appearance of a vigorous leucocytosis, there is also introduced a stage favourable to the preservation of life. Within the limits thus indicated we must endeavour to investigate clearly the therapeutic considerations of every individual case of peritonitis, so as to guard ourselves from undervaluing the defensive means of the organism, and from overvaluing our medicinal remedies.

As from the outset, the *first* therapeutic point of attack is the *retardation of absorption*, so is perhaps the production of a peritoneal *leucocytosis* the *second* postulate which should occupy our endeavours in this connection. With regard to antitoxic measures we must, however, fully confess our incapacity and deficient preliminary knowledge regarding the significance of the various bacteria found in every individual case. We have mentioned that many peritoneal infections come to a stand at the beginning of their course, from the arrest of the progress of the army of infection by adhesion and fixation. The occurrence of these cases depends on the variety of the infecting material, or on the vital energy of the organism attacked, at the time being. Experience shows that age, sex, and many previous attacks of disease (carcinosis), as indicating the "plasticity" of the individual, decide the resisting powers of the peritoneum. We are even in a great measure in the position to check the commencing infection of the peritoneum by a small invasion, and to limit a small absorption surface; by incision and exposure of the infected locality, so that the infecting material may be removed. And we are justified in drawing therefrom the conclusion that the earlier the seat of a peritoneal infection is laid bare with the knife, the more reliably will the danger of further extension of the infection be obviated.

While we must avoid entering on a discussion of the details of the symptoms of peritonitis, especially with regard to considerations of prognosis, it is nevertheless indispensable to point out specially the value—positive or negative—of certain symptoms in determining the indications for operation. The absorption processes in the peritoneal sac are reflected most distinctly in the condition of the pulse—its frequency, the fulness of the blood wave, and the tension or easy compressibility of the vascular tube. In opposition to these characteristics of pulse, nearly all other symptoms sink in the formation of an opinion regarding peritoneal processes; it should be specially remembered that meteorism, or hardness and tension of the abdominal wall, painful tenderness of the abdomen, and derangement of peristalsis are by no means unambiguous symptoms. On parallel lines with the failure of the pulse proceed the remaining vaso-motor lesions: coldness of the extremities, cyanosis, diaphoresis; only slightly decisive are the conditions of the body-temperature. Unhappily, in presence of the main object of present discussion, which is the treatment of peritonitis, I must forego further pursuit of these interesting and important matters, as well as the further dissection of the symptom-complex of peritonitis. I limit myself here now to discussion of the operative and general measures, which come into consideration in presence of a diagnosis of *free, diffuse peritonitis*, especially on the foundation of the type of the appendicular variety; as this is the variety in connection with which the success and failure of a line of treatment can be most readily discussed, and the most frequent inducements by far to surgical procedure in connection with peritonitis are likely to occur. In the first place, it must by all means be emphasised with regard to this condition that it most frequently affects young persons; that the peritoneum therein presents the most favourable conditions for defence; and that the infective material displays a great variety of virulence, according to the preponderance of one or another species of bacteria. We see a great number of cases of diffuse peritonitis following appendicitis become spontaneously encapsuled, and producing by this process simple conditions for treatment; yet is this process of encapsulation in its course, as a whole, too unreliable to be prognosticated that one in a condition of fully developed peritoneal disease may be brought to reckon with, with a possibility of a successful issue attainable thereby; much rather is it in all cases of free diffuse peritonitis demanded that operative procedure should be immediately adopted when the symptoms of failure of the medulla oblongata have not advanced so far that coldness of the extremities and cyanosis have set in to indicate the last stage of poisoning. In such cases, the chances of success of operative treatment can scarcely be said to reckon; when such is carried out the record of recovery approaches a vanishing quantity.

While those last-mentioned phenomena are so significant that they constitute an almost absolute contraindication to operative procedure—and the observation holds good for all cases of peritonitis, even of the most varied origin—yet, in my opinion there exists no peritonitis symptom which forms an absolute contraindication to operative interference; and directly in the line of this perception lies, according to my view, the most important progressive step in the whole of the modern therapeusis of diffuse peritonitis.

With regard to the employment of *narcosis*, the opinions of operators are divided. It is true that the method in which small quantities of morphia are introduced hypodermically, followed by the use of a small quantity of anæsthetic administered by inhalation—the most appropriate being ether—reduces the unfavourable sequelæ attributable thereto to the smallest conceivable proportion; yet it is difficult to estimate rightly its influence for the time being in the mischief to the vaso-motor centre which has been already produced by the disease.

We must all admit that at the present day we can carry out an occasional experiment in the operative therapeusis of peritonitis without the full accompaniment of the influence of narcosis, or without further anticipation of success when it has been carried out. On the other hand, success may well follow when the peritoneal patient, who has previously been so sensitive and so restless, is operated on under local anæsthesia of the parietal peritoneum. For my own part, I prefer employment of narcosis in the way above described. The chilling of the body during the preparation for operation, and whilst the latter is proceeding, may be guarded against by heating the room and the operation-table, and by warmly wrapping up the parts of the body not involved in the area concerned in the operation; also the employment both *before* and *during* the operation of subcutaneous (or intravenous) injections of fluid at a temperature of 30-40° C., which may be judiciously adopted as auxiliary sources of heat.

With regard to the effect of cold on the exposed peritoneum, the extent of the incisions (or incision), the volume of intestine which has escaped through the opening, and the means for limiting the loss of heat by continuous irrigation with warm neutral solution, or by operating under a warm-water spray, are of the most telling influence. Surely as regards the loss of heat, the conditions will be the more favourable, as a smaller proportion of the viscera are drawn out of the abdominal cavity, or a shorter time is occupied in this act. Of specially fatal influence is the taking out of the intestines, when, with a rapid pulse, the temperature of the body has fallen below 37° C. In such cases the unfolding of the intestines comes to be a fatal procedure. Where the temperature range is high, the unfolding of the intestine need not necessarily produce such deadly effects on the heat-maintenance; nevertheless, these cases are mostly so framed *a priori* that, according to the range and intensity of the infection, the *complete* unfolding of the intestine is not requisite. Nevertheless, we may restore even the deadly chilling effect of the unfolding of the intestine to a favourable estimate, when it has been proved in the progress of an operation that the progress of absorption—with respect to the retardation of absorption—and its central effects—have been favourably influenced thereby. Regarding this question there is, up to the present, but little univocal matter for proof available in connection with either man or the lower animals; with this exception, that in every case in which a portion of the peritoneum has been exposed to continued contact with the atmospheric air, absorption has ceased after a few moments. It appears, indeed, in accordance with our former investigations regarding the extent of our knowledge of infection processes, that if we could rapidly change the complicated folds of the peritoneum into one free (plane) surface, we could in a short space of time effectively exclude all the dangers of absorption. This possibility fails, of course, in presence of the known anatomical conditions. We must, accordingly, as can easily be understood, confine our efforts to a limited range with regard to the retardation of absorption; but we surely go wrong when we have recourse to measures which promote absorption as remedies during the progress of diffuse peritonitis, or other corresponding means of purely empirical origin, and attribute to them favourable effects by the production of absorption. Yet I venture to affirm that whenever depleting measures have been employed in an established peritonitis without mischief resulting, the extent of that peritonitis with regard to the peritoneal surface engaged was but proportionally small.

All experiments with the view of wiping off all agents of infection from the peritoneum after exposure of the viscera, and thereby effecting a restoration of the peritoneum to its healthy state, or whatever other results may be fantastically announced, lead to their own discredit by the naïveté of their representation.

From what has been said, it must, however, happen in cases of interposition of dead material between large portions of the affected peritoneum, that when these are brought into contact with the outer air it is possible to reduce the absorption process in those sections to such a degree that it will be of no further importance. We are in the habit of removing an interstitial exudation or the pressure of a foreign body by laying open the same; we thus check the progress of infection in the shortest space of time possible, and bring the absorption of infective material to a close. If we now replace interstitial by substituting intraperitoneal, we obtain a corresponding result; but it naturally can no longer be expected to follow when the regulating mechanism of the vaso-motor nerve centres has undergone extensive derangement. This is of customary occurrence in the forms of the disease known as peritoneal sepsis and dry peritonitis; in which accordingly we can reasonably entertain but little hope of good results from the tamponade.

Of decisive significance with regard to the preservation of life may be the origin, or the increase of *meteorismus*, after incision and repeated tamponade. This phenomenon is in the greater number of instances not so often the result of intestinal paralysis as of intestinal fixation—whether this latter be the effect of adhesions of individual segments of the intestine to one another which have been already completed, or of kinking of an intestinal loop, or of the compression of an exudate. Let such cases not be influenced and checked by application of hot compresses to the abdomen outside the area involved in the operator's incision, or regularly repeated washings-out of the stomach (three to five times daily), or by the use of lavements, or—from two days after the operation—the internal administration of small quantities of a mild aperient agent (Carlsbad salt), and an imperative demand may arise, even during the course of the operation, for the adoption of a fæcal fistula; although in the cases observed by me, even of very many of adoption of intestinal fistulæ, in not a single instance was the condition of the peritonitis so modified thereby that the patient could be restored by its means; although in other cases I have possibly adopted this procedure without detriment to the patient. With regard to this point, however, the proceedings are by no means closed; and the investigation of the desirability of adopting such enterostomy so often arises in our experience, that only cases which have been critically observed can be decided on the grounds of the practical advantage obtainable.

We may, indeed, adopt, without exception, the rule that the primary incision should be made in immediate proximity to the seat of the original infection, after which, according to the degree of extension of the peritonitis, one or more incisions of moderate length may be made in one or two other regions of the peritoneal sac for the purpose of conveying away the infected materials and limiting the surfaces of absorption. In cases of appendicular peritonitis, I have more and more decidedly returned to the simplest modes of incision in one or two—seldom more than three—places. The first of these is in the right inguinal region, then usually the left inguinal region, and occasionally the middle line at the level of the umbilicus demands incision; while, at the present day, I have seldom recourse to a primary opening in the vagina or rectum, or adopt Rehn's proceeding of incision of the posterior abdominal wall.

The appropriate and circumspect after-treatment which was adopted in many cases of extensive peritonitis, and conducted the majority of them to a successful issue, has been already published with thorough discussion in my communication to the Surgery Congress of 1902. Lavage of the stomach, care of the passage of the alvine evacuations, pedantic attention to dietetics, water-supply, and preparation of the food, even to the adoption of subcutaneous introduction of nutriment, belong, side by side with the scrupulous care of the progress of the surgical wound, to the foremost essentials of therapeusis. Many of the derangements are accessible by symptomatic medication, and should be treated accordingly.

Completely analogous to the course of treatment of diffuse appendicular peritonitis, as thus sketched in its principal outline, should be the conduct of the forms of peritonitis of a different origin; and all are, accordingly, here disposed of by the investigation of the appendicular type. Correspondingly successful in our practice has been the treatment of peritonitis derived from lesions of the biliary vessels, and the same may be occasionally adopted in the perforation peritonitis derived from the stomach and small intestine, and even in cases of this inflammation which owe their origin to internal strangulation; in the cases which follow operative procedures—especially in patients affected with the carcinoma cachexia, and which develops upon the protrusion of neoplasms of the stomach-wall—the results are proportionally discouraging.

A glance at the statistics of the progress, recovery, and mortality of the various forms of peritonitis shows us most strikingly the contrast between the success and failure of our measures, according to the etiology of the peritonitis; yet it should never be forgotten that the physiological mechanism present in each of these cases was originally the same, and that it was only through the earlier or later paralysis of its cardinal functions—from the individual varieties of tissue reaction to the attack of infective invasion, that the terminal effects were so different. A careful comparison of conscientiously arranged tabular views of the success and failure of the modes of treatment adopted by various operators would enlighten us regarding the advantages of individual therapeutic measures. When, accordingly, we are led on the ground of accurate physiological and pathological ideas in a trustworthy pathway to better success by the adoption of other principles of treatment, then will every practitioner who has only the welfare of his patient in view, be ready to test the better method of attacking the disease, and possibly to adopt the same.

THE IRISH MEDICAL ASSOCIATION: ITS RE-ORGANISATION AND ITS FUTURE. (a)

By R. B. MAHON,
Ballinrobe.

II.

WITHIN very recent memory the inhabitants of an empire of vast extent and power stood in spirit expectant by the bedside of the ruler's wife. A male heir to the great throne was expected, and the event was satisfactory. Descending to lesser things, we may say that in like manner now stand, also in spirit, the medical profession in Ireland at the bedside of the Irish Medical Association, brought to travail, wishing it a joyful hour, a happy accouchement, bringing into the world its male heir or new policy. Floreat! May it be lucky!

In such a moment why should a disagreeable old piece of Latinity obtrude itself on the memory, calling loudly for expression?

"Parturiunt montes, nascitur ridiculus mus." Mere disagreeable Latinity, yet pithy, expressive. Nay, more, probable; for is our judgment not guided by, some even say wholly based on, experience, and how often has our Irish Medical mountain laboured, travailled and brought forth merely ridiculous *female* productions, useless save for more futile breeding of dead dogs or such like—unsatisfying to the expectations?

Consider in this light for a moment that last abortion or miscarriage, the recent general meeting. At certain expense in time and money, a number of members of our Irish Medical Association come together at Killarney, listen to platitudes oft repeated, dine and return home, having no doubt with a good deal of personal satisfaction ridden through the Gap of Dunloe. Other clear result one cannot see. True it is, Dr. Donnellan of Castlerea, anxious to *do* something, brings in a resolution to the point, only to find that in some strange manner the meeting considers it premature. Whereupon Dr. Donnellan withdraws his resolution, wondering no doubt and unconvinced; forgetting, indeed, the incredible vanity that stifles all constructive effort in this wonderful Association. So much as a result of this general meeting.

Going back somewhat further in time, let us look once more on the formation of the Co. Mayo Branch. The promoters of this combination of medical men hesitated long before throwing in their lot with this Irish Medical Association. Decided on doing so in the end, only with the hope of rousing the medical men in the country to capture the Association, to make it their own, evidently to change it, and, so changed, to make it a powerful engine for the shaping of their ends. Most futile hope, as events showed; this moribund incubus of an Association only damping the spirits. Still, this Co. Mayo meeting did at least one thing: it brought a policy before the medical men of Ireland, the constituent parts of which we may now usefully rehearse:—

(a) Being the second of series of articles specially communicated to the columns of the MEDICAL PRESS AND CIRCULAR by prominent members of the Irish Medical Association.

1. Fixed minimum rates for locum tenens and extra work.
2. Annual holiday of one month, substitutes to be paid out of public money.
3. Superannuation on the English plan.
4. Minimum salaries for office (a temporary measure pending the granting of the first three claims).

Such the Mayo platform or programme, of which the first and second items were won, not without hard fighting in Mayo and elsewhere. Now they are shamefully abandoned in many places, a "powerful reformed" Association notwithstanding. The third is still unwon. The fourth mature consideration induced the Mayo men and the friends who thought with them to modify, to urge on the Association the reduction or abandonment of this minimum.

On the heels of this programme came the Enniskillen meeting of the Irish Medical Association, enthusiastic, oratorical, even witty, drowning in a storm of disapprobation those delegates who spoke mere common-sense. And for results? Oh, you dispensary doctors, who have been described almost poetically as dying at your posts, working day and night, in fair weather and foul, for the good of humanity, for the good of the country, for the good of everyone save your foolish "noble" selves! What results? One of you can now write officially (of himself) in some such words:—"So many years, O God, and still no hope, nothing done to better a miserable condition of life"; while within a day's march or so, two other medical men are wooing, it is insinuated, in a Jupiter and Danaë manner, a divided salary, a mere pittance indeed. What calculations have we not read of a dispensary doctor's expenses, of house-rent, rates, taxes, servants, cost of living, cost of horses, traps and such-like, of 200 into 100 ought times and ought over!! Most amazing, then, to hear of men (no doubt largely humane and generous) falling over one another, rumour says, even paying heavily for the privilege of occupying such positions. Stands it not printed in the public press how at a recent election to a dispensary vacancy a guardian proposed that the election be by ballot, as it was common report that the guardians were bribed! Bribed! Oh, Surgeon-General Evatt, and you past-presidents of the Irish Medical Association, think of that! Bribed! In spite of a Corrupt Practices Act, a "determined agitation" and an appeal to all whom it might or might not concern, even an appeal to the *women* of Ireland, the men being apparently useless. What is a bewildered public to think? A bewildered public is apparently conscience-stricken; would even, as a ratepaying public, willingly open its pockets to amend such a wretched lot were it not for this strange anomalous desire to fill all these so miserable positions soon as vacant. Wondering, too, no doubt, at the folly of those continuing to hold such offices at 200 into 100 ought times and ought over; sceptical, it would seem, of excessive brotherly love, awaiting a crisis of universal resignation which comes not.

In the midst of such distraction, what can our Irish Medical Association do? Our Irish Medical Association can apparently do—nothing, save, perhaps, querulously to complain of extensive arrears of subscriptions, of lack of interest in reform, to hold quarterly council meetings productive of much talk, mere goose-like babble, meaning but little. Has not a *deus ex machinâ* in the shape of Surgeon-General Evatt, of "disciplined military experience," sprung forth, worked by transpontine friends, whereupon hope is renewed? Surgeon-General Evatt delivers himself also of his offspring or report, which, fortunately for its continued remembrance, contains a picturesque phrase, "the ultimate peasant," which pleasantly keeps him in memory, which, apparently by its very quaintness, induces our Irish Medical Association to spring him forth again, spending much money and not a few tears over the result.

"Tantæne animis cœlestibus iræ?" For are not our Royal Colleges of Surgeons and Physicians naturally indignant, shaking off their habitual somnolence with hysterical clamour for apology?

Such again by way of result, with obscurer accompaniment of increased competition for soul-destroying, man-destroying, pocket-destroying, dispensary appointments!

An Irish Medical Association becomes itself bewildered, knows not where it stands, considers that it will, above all things, reduce the number of its council, calls wildly here and there for advice, encouragement, especially for subscriptions. Invertebrate! And yet, is it so much to blame, or is the fault not rather with the members or, more, the non-members, for are not two-thirds of our medical men in this latter category? To apostrophise again: Tell us, you dispensary medical men, are you really contented with your lot or not? Are all these statements, instances, opinions, we have heard, merely Irish high-falutin', or is your lot so poor, so hard, so desperate? If it be thus hard and desperate, then end it or mend it. But how mend it? I think it is Mark Twain who tells a story of a virtuous nobleman who was imprisoned in a castle for twenty years without anything to eat or drink. At last, driven to despair, he opened the door and walked out. *Verb. sap.* Here is a policy. How carry it out? Plainly and simply enough, let us but have the courage. Begin the matter with a plain, temperate statement of grievances to the Local Government Board, with a programme for amendment, and for which amending programme I recommend the following three points as vital:—

1. Superannuation as a right.
2. Periodical increase of salary to a maximum, leaving initial salary, if necessary, to be fixed by the laws of supply and demand, or fixed at a low minimum, say, £100 per annum.
3. Repeal of Clause VI. of Local Government Act No. 2, or, failing that, parliamentary provision for the moiety of expense incurred by the adoption of this programme.

To which plain, temperate statement, what if the Local Government Board return a "non possumus" or even a "nolumus"? In this event, not indeed improbable, then I say arrange a proper legal plan of wholesale resignation after conference with all concerned. Preliminary to which, let the whole country, blacklegs and white, be organised into solid county branches, refusing no man admittance to the ranks. Here, then, is a policy, not indeed original but perhaps forgotten, one which will test alike the reality of this demand for increased salaries, for superannuation, for improvement, as well as the backbone of the agitators. Is it Utopian ? If so, then let us cease to play at agitation and settle down to our proper business, forgetting that 200 into 100 goes ought times and ought over, remembering only that "we doctors are feeble folk like the rabbits." Rabbits or hares, *lepus timidus*, fit to be hunted or frightened by various scaring agencies. But is it Utopian ? I say no ; let but one blast be blown on the resignation trumpet and down fall the walls of Jericho, carrying with them much in the way of obstacle, reduced to mère débris. Oh, Poor-law medical men of Ireland, what a victory —for rabbits ! Have you the courage ? Is not this a live policy, a tonic and stimulant one ? But with an Association dying of gangrene of the extremities, and for panacea or curative treatment mere goose-like gabble of quarterly or monthly council meetings, chairman declaring resolution carried, no one caring whether it is or no ; of such I can only say, Faugh !

A NOTE ON

PUERPERAL CONVULSIONS.

By ALEX. DUKE, F.R.C.P.I.,
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The consensus of medical opinion inclines to the belief in a morbid poison circulating in the blood as the cause of above complaint. The symptoms and character of the convulsions seem to point to the kidneys as the primary movers, but some consider the liver as first offender.

As the important organs first named may have to assist the liver and also do the double work for both mother and fœtus, they must at least be considered of importance in the treatment adopted. It is obvious that if poison of any kind circulating in the blood could be sufficiently diluted to neutralise its effect on the system, we should be doing something towards the cure. But even were we able to do this we should probably find such treatment *alone* insufficient and we are obliged to supplement the treatment by free purgation, diaphoretics, and saline transfusion, with sedatives to control the fits.

When listening to the interesting paper by Dr. Boxall and the remarks made thereupon, at the Leicester Meeting B.M.A., I was surprised that more mention was not made of the value of venesection which, by the removal of some at least of the poisoned blood, should materially assist in the treatment.

Having both seen and experienced in my own practice the value of venesection to the amount of 17 to 20 ozs., before the days of saline transfusion, I venture to recommend that both venesection and transfusion of normal saline fluid be carried on *simultaneously*, more especially in hospital practice, where every facility can be obtained.

The bleeding, removing some of the poisoned blood and the saline fluid diluting and supplying the proper volume to keep up cardiac action and also acting as a diuretic in addition. Time can almost always be found between the fits for carrying out my suggestion, and in exceptional cases, where fit followed fit in quick succession, morphia could be injected so as to obtain an interval in which to perform the double operation. I am firmly convinced of the value of venesection in these sad cases when the pulse is full and bounding, and have only seen two cases die who *had* been bled when the convulsions continued after delivery (which I believe is still the case, after the saline transfusion). "Prevention being better than cure," it is obvious, that if all pregnant women were kept more under observation for the last three months of pregnancy, and the bowels, skin, and kidneys assisted in carrying on their functions, we should hear and see less of puerperal eclampsia.

ON BOLDNESS IN THE TREATMENT OF SOME PHASES OF PNEUMONIA. (*a*)

By ALEXANDER MORISON, M.D., F.R.C.P. Lond. and Edin.
Physician to the Great Northern Central Hospital, and to the Children's Hospital, Paddington.

Among the leaders in the revolt against indiscriminate blood-letting in pneumonia about the middle of the nineteenth century was Dr. George Balfour, of Edinburgh, a notable authority in his day on the nature and treatment of heart disease. He was, however, apparently so swayed by his conclusions as regards the injuriousness of venesection in inflammation of the lungs that in his excellent lectures on diseases of the heart he makes no mention of the utility of blood-letting in affections of that organ.

In order to justify in advance the title given to this paper, and to protect myself against the possible accusation of being a sort of therapeutic Ghazi, running amok against dangerous complications of disease, I shall state now that boldness in the employment of any measure should pre-suppose some positive acquaintance with the principles warranting energetic action. The bold use of an empirical remedy can only be justified by a record of unvarying success, or by a practical innocuousness of the drug or measure, even when it fails to accomplish its object. I shall, therefore, chiefly deal in this paper with boldness in the treatment of pneumonia on those principles of which we may assert, with some show of reason, that we have an approximately adequate knowledge. It was my design to have added a few illustrative cases, but the limits of time and space compel me to forego this clinical chronicle, and I must ask you to assume that the positions I shall maintain are based upon actual experience, and upon my interpretation of the results of the employment of those measures which have been pushed with boldness in the treatment of this disease.

What, then, are those lines on which we are justified in acting with boldness in this matter ?

The bacteriological causation of pneumonia is of too recent date, and our knowledge of the causes and consequences of inflammation thus originating too limited, to allow of dogmatism in this sphere ; while it is common knowledge that the abortion or removal of pneumonic conditions by serum therapy is not yet possible, although its tentative use under certain circumstances is quite permissible. The future, and perhaps a not distant future, probably holds agencies of this class which will enable us to treat pneumonia with as much confidence as diphtheria, but that time is not yet, and our therapeutic efforts on these lines are purely experimental at present. If, however, we cannot now so scientifically cure our patient as we hope one day to be in a position to do, we may at times actively assist in keeping him alive and in affording him time to cure himself. In the following

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(*a*) Paper read before the West London Medico-Chirurgical Society.

remarks I do not pretend to do more than to deal with matters of common knowledge and if I refer to some facts which are very familiar I must ask your forbearance. The signs of a palpable inflammation, as determined by long observation, are pain, heat, redness or congestion—superficial, or deep—and swelling. The issue of these conditions is in resolution, or in one or another form of destruction of tissue, over which the surgeon has in some cases more, and in others less, power of beneficent action.

The cardinal signs of inflammation of the lungs—of pneumonia—are fever, accelerated cardiac and respiratory action, and local changes of pulmonary texture by engorgement, swelling, and consolidation. Pain, although also a minor state in visceral inflammation, does not play so prominent a *rôle* as in the inflammation of parts more fully innervated by the somatic nerves. The issue of these signs of pulmonary inflammation is in defervescence, cardiac and respiratory ease or retardation, and in resolution; or in the delay, postponement, or prevention of the crisis of a terminable pneumococcal inflammation, by an engrafted streptococcal or other infection of indefinite course, leaving too frequently in its train death from cardiac failure; or the supervention of more chronic local destructive processes, over which the physician and surgeon have sometimes little and sometimes no power of beneficent action.

If the cardinal signs of penumonia to which I have referred be moderate in degree, and their unfavourable possible terminations not clinically declared or prognosticable, there will, of course, be no necessity for any boldness in the means used to antagonise the various evidences of the inflammation. The less a pneumonia progressing towards a favourable issue is interfered with the better for the life of the patient, and the better also for the reputation of the physician. By all means let the patient have his mild diaphoretics, assist the evacuation, if need be, of his *primæ viæ*, rest his body, and if possible his mind, give him food and drink conducive to the sustenance of his strength and the elaboration of the protective agencies in his own body. If he be sleepless, let him have a suitable hypnotic. To do all this is important, it *does* help the patient; and the physician, although not active, is on the alert, or should be, for graver contingencies. It may be the good fortune of both that nothing more is necessary. Statistics, which we know are not to be prized too highly, show that with every so-called system of treatment patients will in many cases recover. This is true of systems whose keynote is to do little or nothing, and also of systems which do not err on the side of inactivity.

The conclusions as to the effects of treatment in the days prior to the time when accurate physical diagnosis became possible are not to be trusted. Some who survived much blood-letting in the past, without doubt, had not the local conditions which were assumed to be present when that measure was put in practice. The favourable statistics of the inactive school of a more recent period merely prove that a lung inflammation, like an inflammation anywhere else, will resolve and issue in recovery in many cases, if the patient be not killed by too heroic and altogether unnecessary attempts at rescue from a dissolution, equally unnecessarily assumed to be imminent. The conditions in these cases remain within the compass of the recuperative powers of the patient as a whole, and of his individual organs to withstand the onslaught of the disease. But, on the other hand, there may be a threatening urgency in the degree in which the cardinal signs or effects of the disease manifest themselves, which leaves no place for inactivity—in which inactivity, if it be the attitude assumed, cannot be regarded as masterly, but may be highly culpable,—circumstances in which the reduction, if possible, of the threatening signs, to a degree controllable by the inherent powers of the patient, must be sought by the bold use of agents or measures directed on lines or principles of which we ought, in this twentieth century, to possess a comparatively adequate knowledge.

The phenomena usually presented at the necropsy of a patient of average vitality, who dies of pneumonia are these: The affected portions of one or both lungs show red or, grey, or both red and grey, hepatisation, with more or less congestion of such portions of the organs as are not already involved in the consolidative process. The heart contains coagulum (it may be partially decolourised), especially in the dextral chambers, and in the larger branches of the pulmonary artery. The left auricle also may contain a considerable amount of coagulum, but the left ventricle is usually contracted and empty, or only holds a little agonal clot. The other organs exhibit more or less passive congestion. These are the evidences of an increasing difficulty in the blood reaching the left ventricle for systemic distribution. They are the phenomena of asphyxia and cardiac failure. To what factor or factors are they chiefly due? Is it that engorgement and consolidation of the pulmonary textures offer a serious impediment to a considerable quantity of the venous blood being propelled through the pulmonic circuit? I think not.

When crisis occurs the pulse rate falls, and the dyspnœa exhibited by the patient a few hours previously also in great measure, and as a rule, subsides. There is at this time, and under these circumstances, no material alteration in the degree of general pulmonary blockage, vascular and other. The latter, therefore, cannot be the essential cause of the dyspnœic and asphyxiant phenomena in pneumonia.

To what, then, are these due? Chiefly, I believe, to the *symptomatic tachycardia* exhibited by such cases; for with the crisis these signs subside, and the chambers of the heart both fill and empty more completely. While expressing this opinion, I do not wish to minimise the importance of the depressing effect of the toxins of the pneumonic process on the circulatory and respiratory functions, but we know that in non-toxic and non-febrile states tachycardia is alone sufficient to induce cardiac failure, with retrogressive dilatation of the chambers of the heart, and we may, I think, reasonably assume that the symptomatic tachycardia referred to also plays an important *rôle* in this respect in pneumonia. If this be granted, of what is the tachycardia symptomatic? What is its proximate cause? Doubtless in greatest measure the pyrexia associated with the inflammatory process, whatever the essential cause or causes of the latter. The reduction of fever, therefore, and the conservation and, if need be, relief of the overworked heart, are the chief points demanding attention in the management of the mechanics of the pneumonic process when this threatens the life of the patient; while the maintenance of a proper quantity and quality of blood through the channel of nutrients is all we can rationally do at present to enable the patient to outlive the essential causes of the disease. But, as I have already stated, this does not exclude the use, for example, of anti-streptococcic serum, if such an engrafted agency be found to be active in any particular case. These, then, being the objects to be kept in view, how is the attempt to attain them to be made?

(1) In the first place, how is the fever attending the pneumonic process to be kept within bounds, or the attempt made to keep it within bounds? We may, of course, use various antipyretics of a chemical kind, which will temporarily reduce fever by inducing perspiration, but the more powerful agents of this class cannot with benefit be continuously employed for any length of time, and milder diaphoretics are, under the circumstances, of little value as antipyretics. The direct physical agency of cold, therefore, seems best calculated to counteract the effects of abnormal heat. In one way or another water, in various forms, has been employed for the reduction of fever; and in the treatment of pneumonia Dr. D. B. Lees has drawn special attention to the value of the local application of ice to the neighbourhood of the inflammation

In my own experience I have found such an application of ice to the surface of the body somewhat trying to many patients, while children frequently become very restless under its employment in this manner. Moreover, as I shall presently maintain, our object in using ice appears to me to be indirect rather than direct, and its application near the seat of disease therefore unnecessary. I have consequently made a practice of applying the ice-bag to the head rather than to the surface of the thorax. Thus used, it is comparatively easily tolerated, and appears in some cases to induce sleep by reducing the fever, and probably also by the direct transmission of cold by the sensory nerves to the deeper nervous centres. In this situation it may be kept more or less continuously applied, so long as the temperature is above 101° F. Below that point, in cases with good reaction, the febrile movement is unimportant and cold depressant.

This statement cannot, however, be made without qualification. A higher temperature may in many cases be borne with impunity, and on theoretical bacteriological grounds, in the opinion of some, with advantage, as tending to shorten the life of the pneumococcus. But it must be borne in mind that an apparently robust individual may be the subject of an unsuspected fatty degeneration of the heart, or of some other form of cardiac disability, and that if we submit him to the uncurbed riot of a pyrexial tachycardia we may shorten *his* life before we seriously inconvenience the pneumococcus. Even, therefore, by risking the theoretical extension of the latter, I maintain that it is wiser to endeavour to reduce fever and its consequent tachycardia. In practice it will be found that this is a difficult matter, but in my opinion it can best be accomplished by the measure I have recommended.

As, moreover, essentially visceral inflammations are frequently attended with little pain, unless neighbouring structures, innervated by the somatic nerves, are simultaneously affected, the local use of ice does not appear to be indicated, while the pain of pleurisy is best and most promptly relieved by the application of a few leeches. Regarding ice, as I do, as an antipyretic in pneumonia, and not as a local antiphlogistic, its application to the head appears to answer every purpose it is capable of effecting. I do not, however, deny that thus used it may, by reducing the respiration and pulse rate, directly tend to conserve the irritability of the centres regulating those functions. In apyretic tachycardia of neuro-muscular origin, it has, applied thus, appeared to me to be of use in steadying the action of the heart and reducing its rate, and it probably acts thus, also, in a measure, under the circumstances we are considering.

(2) THE CONSERVATION AND RELIEF OF THE HEART.

In considering this point, we have to bear in mind the neuro-muscular, hæmic, and mechanical factors underlying cardiac action. Remembering the anatomical condition of the heart found after death from pneumonia, to which I have already referred, the general tendency to repletion of the right heart and depletion of the left, as in all tachycardial and asphyxiant conditions, the maintenance of the irritability of the organ and the relief of the dextral chambers, are the chief objects of the physician. To maintain the irritability of the heart the hypodermic injection of strychnine pushed in proportion to the debility of the patient is the most useful measure. Provided the patient manifest the physiological antidotal condition to the over-action of the drug, namely, exhaustion, a carefully watched patient can tolerate repeated and considerable doses of strychnine without injury. I have, under these circumstances, given 8 to 10 minims of the liq. strychninæ hypodermically in pneumonia every four hours for days with benefit. Digitalis and strophanthus I rarely now use in pneumonia, as the action of these drugs on a comparatively empty left heart tends, in my opinion, rather to retard than promote the circulation.

Useful as *opium* is in inflammation of the heart, when also its retardation of respiratory action is noteworthy and desirable, the use of this drug in pulmonary inflammation is not so suitable. With a fairly full pulse and limited implication of lung, opium, as a hypnotic, is at times serviceable in pneumonia in the adult, but I confess that I have rarely used it, even under these circumstances, without some apprehension, in this disease. On the other hand, when the lung is burdened with much bronchial or alveolar material in a softening condition, and the patient threatens to drown in his own secretion, the bold use of turpentine internally may be of much value.

Whether turpentine has any directly antiseptic value under these circumstances I cannot positively affirm, but I have known recovery to take place under its use in broncho-pneumonia of a prolonged and septic type, when the condition of the patient appeared to be quiet desperate, and after the appearance of superficial purpura. That it renders the blocked air-passages more pervious is, I think, certain.

(3) THE RELIEF OF THE HEART BY BLOOD-LETTING.

The last but not the least important point to which I shall refer in considering the bolder treatment of some phases of pneumonia is the question of blood-letting.

In the days of heroic venesection the object with which this measure was employed was the prevention or limitation of pulmonary engorgement. Inflammation was regarded as a purely mechanical determination of blood to a part, which might be prevented by opening a collateral tap in the circulation regarded as a hydraulic machine. Discouraged by the high rate of mortality in the disease under ordinary venesection, some advocated a greater boldness in blood-letting, and bled, *coup sur coup*, repeatedly and largely, in the endeavour to effect by this means what a milder bloodshed failed to do. But by this "jugulant" method, as it was called, our predecessors also largely failed, although statistics occasionally appeared to support each fresh departure. The general sense, however, was one of failure, and, like the pause after a great war, there was for a time so complete a truce to blood-letting that generations of students grew up and were dispersed into practice with nothing less than a horror of blood-letting in every form and under all circumstances. The public naturally, in time, took the same view, and he is a bold man who even to-day calmly proposes venesection in private practice in many cases, even although all the indications point to its necessity. I recently met a *confrère* in consultation, who told me that he had sent for me simply because he dared not himself bleed an urgently orthopnœic patient with broncho-pneumonia. We together relieved the patient of twelve ounces of blood from the arm at once, and with immediate benefit.

From what we now know of the nature of the pneumonic process we can understand why the bold preventive methods failed, as methods preventive of the progressive consolidation of a pneumonic lung, whether by bleeding or by ice, or by any other means at present known to us, are bound to fail. The particular attack of pneumonia with which we have to deal may be severe or may be mild, but being micrococcal in origin, the severity and duration of symptoms will depend upon the nature and virulence of the infective agent or agents concerned, although, no doubt, they are also influenced by the state of the inherent powers of resistance of the patient.

In the case of limited and easily accessible inflammations, such as otitis and pleuritis, associated with pain, a local loss of blood may, we know, by relieving tension remove pain and reduce inflammation. But the argument from these facts to the more general effect of blood-letting on visceral inflammation has not been found in practice to hold good. Boldness, therefore, in endeavouring to oust the infective agent by venesection, or to limit the pulmonary engorgement, is irrational. That will only be possible when we learn how to kill or starve the pneumococcus and associated organisms *in situ*, and in the general circulation, by some bactericidal or antitoxic serum.

The object of venesection, like that of the application of ice, as I conceive it, is not to prevent inflammation of the lung, but to maintain the effective action of the heart. It is directed against cardiac failure, not pulmonary engorgement, and it is only when cardiac failure is threatened that venesection is admissible. As, moreover, such failure may occur more than once in the course of the same case, the same heart may have to be relieved by venesection on more than one occasion. The indications for the employment of venesection under these circumstances are—urgency in dyspnœa, with more or less duskiness or cyanosis of countenance, usually accompanied with fulness of the superficial veins, and diminution in the size of the radial pulse.

The precise delimitation of the area of cardiac dulness under these circumstances is not always an easy matter. The intervention of the sounding board of the sternum, together with the accelerated rate of respiration, and the presence of adventitious sounds in the lungs themselves, make it difficult at times to determine with exactness the extent to which the dextral chambers of the heart are dilated. Fortunately, such accuracy of physical diagnosis is not necessary to guide us, for the more general effects already mentioned, produced by cardiac conditions, are sufficient indications of the state of the heart. It is probable that one reason why the large blood-lettings of the past were not even more fatal than they were, was the fact that venesection was practised early in the disease, when the patient's strength was frequently fairly good. Now that we regard the justification of blood-letting in pneumonia to be in the presence of signs of cardiac failure, whether these occur early or late, the scope of venesection in such cases is, naturally, much and properly restricted. Of blood-letting late in a protracted case I have no personal experience. At this stage the diminished absorption of food from the digestive tract is, in itself, a mode of depletion *a tergo*, and any additional blood-letting appears to be inadvisable. But, even under these circumstances, if the retrogressive stasis in the circulation appears to be a dominant factor in the situation, it is conceivable that venesection to a moderate amount may be permissible.

As regards the *amount* of blood to be withdrawn to procure relief, eight to twelve ounces, in presence of the signs of venous turgidity to which I have referred, may suffice, and the more rapidly they are withdrawn the greater will the effect be. But the quantity abstracted must be regulated by observation of the effects of the measure upon each case, and the average quantities mentioned exceeded or diminished accordingly. In the case of children, a few leeches applied to the side, or in the right hypochondrium, may be sufficient.

A good deal of controversy of a theoretical nature has been raised as to whether any, and if so only a temporary, effect is produced upon the embarrassed circulation by blood-letting under these circumstances. That an effect is produced cannot, I think, be reasonably questioned. That it is only temporary may be admitted, *provided*, we also admit, that the more effective action of the heart which may ensue is maintained by other means, although initiated by blood-letting. Nor is anything except *such* temporary relief expected, desired, or necessary, as a result of venesection, to justify its employment. Relief is experienced by the patient and observed by the physician, and such temporary relief of distensive tension, coupled, as it should be, with the bold use of strychnine hypodermically administered, may be all that is necessary to restore force to the pulse and sufficient tone to the dilating chambers of the heart, to gain for the patient that reprieve from death which may make all the difference between the ultimate victory or defeat of his inherent forces over the processes of the disease.

There are other questions in the treatment of pneumonia, such as the value of oxygen gas, the use of alcohol, and the mental phenomena in some cases, which present points of interest. But while anything except a careful use of alcohol may be detrimental, I have, I think, sufficiently indicated the direction in which we have to regain, I would suggest, under more enlightened circumstances, a measure of that boldness in the treatment of pneumonia which was justly discredited when rashness was aggravated by ignorance and the remedy misapplied. Thus was brought about that revulsion in methods which engendered the tamely expectant attitude in the treatment of pneumonia so prevalent even now, which looks askance at any active interference with the course of the disease, and even lauds the fever as a process likely to limit the ravages of the pneumococcus, which we now know may be associated with other and more deadly organisms which may flourish long in the febrile state.

In conclusion I offer an apology for so frequent an allusion to my own experience and conclusions, but general principles appeal most to us when we have personally reduced them to practice. Moreover, the assumption of personal responsibility for statements made, provokes both a more vigorous attack and defence in discussion.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, September 23rd, 1905.

Acne Vulgaris.

In superficial acne, lotions of the face twice a day are very beneficial. Bicarbonate of soda (3 per cent.) spirit lotions to which are added salicylic acid (2 per cent.), resorcin (2 per cent.), or even a corrosive sublimate solution :—

Eau de Cologne, 12 ozs.
Sublimate, 5 grs.

After these lotions cold cream or some other similar preparation should be applied to the skin.

If the skin is tolerant the following mixture might be used on the face once a week :—

Precipitated sulphur, 3 drachms;
Proof spirit, 4 ozs.;
Water, 6 ozs.

Gastric Flatulence.

The medical treatment consists in antiseptics, absorbent powders, laxatives.

Peroxyde of magnesium, 6 grs.

For one wafer to be taken half an hour before meals.

After the repast :—

Prepared chalk, 15 grs.;
Bicarbonate of soda, 8;
Calcined magnesia, 8.

For one powder; to be taken in water or aniseed tea.

In case of pain or burning in the stomach, opium and belladonna might be associated to the powders :—

Prepared chalk, 15;
S.N. of bismuth, ;
Calcined magnesia, 12;
Powdered opium, 1-5th;
Powdered belladonna, ½.

Treatment of Ozæna.

The treatment of this troublesome affection has taxed the patience and energies of many practitioners. Numerous are the remedies recommended for it—irrigation of the nose with solutions of chlorate of potash, boric acid, hermophenyl, oxygen water (3 vol.), &c., followed by a variety of powders given in the form of snuff and general treatment.

Dr. Lubet says the treatment of ozæna is much more simple and should have for principal object the removal of all crusts from the mucous membrane, as where there are no crusts there is no odour. His idea is to stimulate the nasal secretion so that the crusts become detached of their own accord. To obtain that end, he recommends the aspiration through the nose several times a day of a strong boric acid ointment :—

Boric acid, 4 drachms;
Menthol, 6 drachms;
White vaseline, 1½ oz.

The boric acid excites the secretion of the membrane, detaching the crusts and when the patient blows the nose with a certain force, they are expelled. The ointment, however, has the inconvenience of being troublesome to carry about for those whose occupation is constantly out of doors; in such cases it can be replaced by boric acid finely powdered and used as snuff.

Where the mucous membrane is thickly coated by the hardened secretion, it will be necessary to soften it by irrigation. Ordinary boiled water to which a little salt may be added (a teaspoonful for one quart) or a solution of boric acid (30 per cent.) answers the purpose. After four or five irrigations the above ointment can be used.

All the patients got well, but the treatment must be continued for a long time, for with the re-appearance of the crusts the odour returns.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, September 23rd, 1905.

GENESIS OF TUBERCULOSIS OF THE GENITALS IN WOMEN.

This subject is discussed in the *Arch. f. Kl. Med.* by Dr. Merkel. It is said that from two to seven per cent. of all female diseases are tuberculous. As regards frequency, the tubes suffer most, then follow in order uterus, ovaries, cervix, and, least frequently, the vagina. Thus it appears that the higher and least accessible parts suffer most, and that the disease shows a descending tendency and much less frequently one in the opposite direction. In most cases of genital tuberculosis the disease is also present elsewhere. From 4 to 4·30 per cent. of phthisical women show tuberculous disease in the genitals, but the number of cases in which the genital disease is the primary is an almost vanishing one.

In the first place, hæmatogenous infection must be mentioned, especially as regards secondary disease. Infection *per contiguitation* also plays a great part. Here not only pure contact infection comes into play, but also influx from neighbouring parts through the subserous lymph channels. Usually, however, the parts first affected are the tubes, then the lower parts, as if they became infected by the secretion from the tubes passing over them. Most authors recognise a possibility of the tubes becoming infected by free tubercle bacilli passing in from the peritoneum. Those cases are of especial interest that teach the possibility of an infection from outside and leading to an ascending disease.

It has been much discussed whether tuberculosis can ever be contracted by cohabitation. That numerous bacilli may be present in the sperm has been shown by Gaertner in the case of guinea-pigs; and infected male guinea-pigs did, as a matter of fact, infect female ones. On the other hand, no case is on record in which a man suffering from tubercle of the genitals has infected a woman by way of cohabitation. One case is certainly quoted, but when all is known the aspect becomes different. A woman, æt. 25, died of miliary tuberculosis and basilar meningitis, and after death old double caseous tuberculous disease was found in the Fallopian tubes. The husband, who was suffering from so-called hereditary tuberculosis (we shall be talking of hereditary small-pox next), and who had tubercle of the apex, had had the habit of moistening the glans penis with spittle before coitus. If the woman's infection took place in this way, therefore, her disease was not one of genital infection, but an infection by sputum in an unusual situation.

OLIVE OIL IN THE TREATMENT OF DISEASES OF THE STOMACH AND DUODENUM.

A paper on this subject appears in the *Arch. f. Klin. Med.* 84–1–4. After referring to the excellent results obtained by Kussmaul and Fleiner, he mentioned those obtained by Rosenheim and Krönig in stricture of the œsophagus. From these it was not far to go on to other strictures in other parts of the intestinal tract. As moreover, the good effects of pure fat on hyperacidity of the stomach had long been known, it was a still further reason for trying olive oil in cases of spastic or organic narrowing of the pyloric orifice of the stomach. By means of oil roughnesses can be smoothed or smeared over, so that the passage of food over tender surfaces can be made easier. It should also be borne in mind that the oil itself is a nutrient of considerable value.

The oil was either injected into the stomach previously freed from its contents or it was taken by the tablespoonful twenty to thirty minutes before mealtimes. It was always a desideratum that good oil should be used—pure olive oil, and that it should be used or taken warm. The taste left behind after taking could be easily removed by washing out the mouth with hot peppermint tea. Sometimes the oil could not be taken at all, and as a rule the strict oil treatment could not be carried out more than six to eight days at a time. Besides the oil treatment the stomach should be washed out if required.

The first four cases were cases of pyloric stenosis, with hyperacidity after ulcer. There were serious motor disturbances of the stomach in all four patients, as well as more or less marked pain about the pylorus, also loss of weight. In the first three cases any operation was rendered unnecessary by the oil; in all four the pain promptly ceased and the patients gained in weight. At the same time the general condition improved materially.

Cases of chronic ulcer with hyperacidity behaved in a similar manner to the four cases mentioned. In one case the improvement showed itself much more lasting than it had done after other treatment. In one case also of simple ulcer of the stomach the oil treatment had a brilliant effect. The usual diet regulations should, of course, not be omitted. On the other hand the treatment failed in one case.

With the exception of one case none of the patients were kept in bed.

In all the patients who took oil the weight increased considerably; the strength and ability to work also increased at the same time. The chief domain for oil treatment lay in those cases where, from irritation, spasmodic closure of the pylorus took place, whereby the stomach was not readily emptied and remnants were retained. Finally, it was always very desirable to try the effects of oil before proceeding to any operation.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, September 23rd, 1905.

URTICARIA PIGMENTOSA.

AT the Gesellschaft für Innere Medicin, Swoboda exhibited a child, æt. 2½, suffering from urticuria pigmentosa. When the child was three months old the mother took it to the Policlinic with an eruption, which was suspicious of syphilis. Other dermatologists recognised syphilis at once, and it was treated accordingly, without success.

The child was strong and healthy-looking, with the exception of the skin affection. According to the mother the child seemed to be seized with a general disturbance on the third day after birth, with red spots over the body like flea-bites, which she dismissed from her mind as the cause of the child's trouble. Next day vesicles appeared with evident itching, as the child was restless. Two or three days after the redness disappeared, leaving a brown colouration, which gradually grew darker.

Three months passed without anything to note, but the mother about the end of this period observed the child scratching and rubbing itself more than usual. From this we get a glimpse of the urticaria character of the disease with increased vaso-motor changes, which may have lead the earlier investigators to append the qualifying term urticuria in the nomenclature. The mechanical rubbing of the irritable skin seems to be an active factor in the production of the pigmentary surface, as it increases the turgescence of the vesicles that follow. The excision of the skin and microscopical examination confirmed Unna's characteristic description. The prognosis of the disease is bad, medicine having no effect on its course, which runs from ten to forty years.

Vaccination and Cerebral Hemiplegia.

Swoboda showed another case of presumptive hemiplegia, caused by vaccination. The girl is now (æt. 11) paralysed in the left arm, which is stunted in growth.

About the seventh month the child was vaccinated. Before this time it was strong and healthy, never having a previous day's illness. On the third day after vaccination the child became feverish and covered with a scarlet exanthematous rash common to inoculation. In the course of the next month paralysis gradually commenced in the left arm, subsequently extending to the left leg. When three years old the spastic symptoms were strongly pronounced.

When six months old the mother took the child to the Policlinic in hopeless despair of the persistent paralysis. At this time the skin on the soles of the feet was peeling, which led to the diagnosis of syphilis, which was falsified in a few days by clearing off, leaving no trace of the disease. Without any treatment the movement of the arm gradually improved, but has never recovered.

The mother has two other healthy children, but aborted thrice in succession after the birth of the third. Swoboda thought that it might be assumed with some show of reason that hereditary syphilis was the proximate cause of the hemiplegia, while the vaccination was the direct exciting cause.

Bacilli in Urine.

Jehle related the case of a child with bacteria urine. Before the child took measles, and shortly after chicken-pox, it was perfectly healthy. In September the child's aunt observed the child's urine to be thick, white, and smelling badly, with a slimy deposit at the bottom of the vessel after standing a short time. There did not appear to be any subjective symptoms such as burning or pain in micturition; no fever, quantity normal; bowels regular and appearance normal in every respect. After this time, when the urine was first observed cloudy it became more yellow in colour, sp. gr. 1020; reaction very acid, and smell abnormal. Nuclear albumen was present in small quantity. In the sediment with the aid of the microscope a large number of long stiff bacilli, with only a few leucocytes in small groups. The renal element and epithelium from the bladder were quite absent; colouring proved it to be Gram negative. Quantities were regularly drawn by catheter and cultures made every second day, which gave dry, granular colonies resembling bacilli coli, and when stripped off crumbled into pieces. On gelatine the appearance was the same as on agar, no fluid in either case. In bouillon a thick slimy deposit was thrown down, while the fluid suspended broken pieces of bacterial products, but was otherwise fairly clear. By shaking, the bacilli could be distributed through the fluid, but would sink again when allowed to stand. When saccharine substances were used such as glucose, mannit, lactose, maltose, and galactose, the bacteria produced acids and great quantities of gas. Milk was slowly coagulated with emission of gas. Plates with fresh stool were next tried with the same results, giving this typical nondescript colony. Blood serum proved to be a bacteriocide even to a tenth dilution. A drop culture with blood serum only a few short bacilli after twenty-four hours in the control experiment and with typhus serum a confused mass of long bacilli were present.

He concluded that this was a peculiar form of bacteriuria with characteristic changes with blood serum and not affecting the health of the child in any way. Large doses of utropin to the extent of two drachms per day were prescribed without affecting the urine in any way.

Lactic Acid Test.

Cronheim has improved Vournaso's test for lactic acid, namely the combination of iodide and an alkali in the stomach to produce iodoform, which can be detected by its odour. Cronheim now adds methylamin-anilin, which makes it more delicate.

Operating Theatres.

TOTTENHAM HOSPITAL.

Abdominal Myomectomy.—Dr. A. Giles operated on a single woman, æt. 37, who had suffered from menorrhagia for two or three years. The loss at each monthly period had increased progressively in the last twelve months, so that latterly the period lasted sometimes a fortnight or more and necessitated the use of about forty diapers. The patient was exceedingly anæmic from the losses of blood. On admission, the uterus was found to be enlarged to the size of a three months' pregnancy, and the fundus felt uniformly rounded. After opening the abdomen and exposing the uterus, a four-inch incision was made in the middle of the anterior uterine wall; this exposed the fibroid tumour, which was then rapidly shelled out, the uterine cavity being opened in the process. To establish a still freer communication, a portion of thickened mucosa, which separated the bed of the tumour from the uterine cavity, was removed. The uterine wound was then closed up by two sets of sutures, first an interrupted series of mattrass sutures embracing the whole thickness of the uterine wall with the exception of the mucosa, and secondly, a continuous suture of fine silk, to bring the peritoneal edges into apposition. Two silkworm gut sutures were then passed, which were made to include the fascia and peritoneum of the abdominal wall on each side, and also the anterior surface of the uterus. The uterine wound was thus brought into close apposition with the anterior abdominal wall. The abdominal wound was then closed in the usual way. Dr. Giles said that this operation of abdominal intrauterine myomectomy was the ideal conservative procedure in dealing with a large intrauterine fibroid. Its application was, however, somewhat limited, because experience had shown that when the uterus was the seat of multiple fibroids the patient's interests were best served by performing hysterectomy. The practice of dealing with such a tumour by dilating the cervical canal and removing the tumour by *morcellement*, had, he remarked, some advocates, but he considered that hysterotomy was a safer procedure; it was certainly quicker and involved much less hæmorrhage. When a large tumour was enucleated from the uterine wall, it was advisable, he said, to secure drainage by opening up the communication between the bed of the tumour and the uterine cavity. He sutured the uterus to the abdominal wall both to assist hæmostasis and also to render the uterine wound easily accessible in case of hæmorrhage.

The patient made an uneventful recovery and left the hospital much gratified at the thought that she had retained all her organs.

ROYAL EAR HOSPITAL.

Foreign Body in Ear.—Mr. McLeod Yearsley operated on a child, æt. about 5, who had been brought to the hospital, having inserted a blue porcelain bead into its right ear several days before. Numerous domestic efforts had been made to extract it, with the result that there was considerable swelling of the meatus with pain and tenderness. When the patient had been anæsthetised and a proper examination made, which had hitherto been impossible owing to the condition of the meatus, the bead could be partly seen tightly impacted in the narrowest part of the passage. Owing to the fact that the bore of the bead was situated vertically, it could not be made use of for purposes of extraction. The smooth slippery surface of the body defied all attempts at seizing the bead with forceps, and it was ultimately removed by forcing the blades of a stout pair of sinus forceps above and below it and breaking it; the three pieces resulting were then easily removed. Mr. Yearsley said that the foreign bodies which may gain entrance to the external auditory meatus are most varied and give rise to a variety of symptoms. These symptoms, he remarked, depend largely upon the nature of the body, and they may be classified as follows:—(*a*) Bodies which tend to swell; (*b*) bodies which irritate but do not swell; (*c*) bodies which neither irritate nor swell. To the first group belong peas, beans, bread, wool, sponge, &c., all of which swell by absorption of moisture; in the second are insects such as fleas, bugs, the larvæ of the common fly, and bodies which irritate by their shape or by their chemical properties; the third class contains a large number of inert bodies such as shot, beads, stones, &c., which, unless by their size or by clumsy attempts to dislodge them, do not do much harm. The symptoms which arise depend largely, he pointed out, on the nature of the body, the force with which it entered, or the unsuccessful endeavours made to remove it. If the body be situated in the lumen of the passage and exercise but slight pressure on its wall, there may be a little deafness with possibly more or less tinnitus; if it be large or swollen from absorption of moisture, it may cause more or less severe pain, whilst, if it press on the membrana tympani, the pain may be intense. The sinus of the external meatus, or the angle formed by the inclination of the membrane to the inferior meatal wall, forms an easy lodging place for small foreign bodies. Larger bodies often become impacted at the junction of the cartilaginous and bony portions (isthmus of the meatus). In treating cases of foreign body in the meatus, he pointed out that the following four rules should be kept in mind:—(1) Remember the anatomy of the meatus; (2) make sure that there is a foreign body present; (3) unless specially contraindicated, persevere with the syringe; and (4) never use instruments unless under good focal illumination. Instrumentation is, he considered, not often necessary, and in unskilful or inexperienced hands is positively dangerous. Speaking generally, the syringe, he said, should always be the method employed. Its chief contraindications are the presence of a large perforation through which the body could be washed into the tympanum; when syringing causes severe vertigo, or when the body is sharp pointed and likely to be easily made to wound the drum head. When syringing fails, Mr. Yearsley thought, it is often useful to repeat it with the patient on his side with the affected ear downwards in order to obtain the aid of gravity. As regards the use of instruments, whatever method be employed, it cannot, he said, be considered safe unless done with perfect care through a speculum and under good illumination. The want, of the latter is, he thought, probably the most fertile source of unsuccessful efforts and consequent damage. Occasionally, as in the case he had just operated on, an anæsthetic is necessary and in a few cases one may be obliged to turn the auricle and cartilaginous meatus forwards. It should be remembered that in most cases there is no cause for hurry, and in many instances undue haste is to be deprecated. The urgent symptoms requiring action are, he remarked, well enumerated by Zaufal as fever, optic neuritis, choked disc, or even an increase of redness of the disc as compared with its colour at the outset. One word, he said, with regard to the removal of insects. Most of them can be removed by syringing or by floating out with warm oil or water. Larvæ require picking out with forceps, owing to their habit of attaching themselves to the passage. They should first be killed by the instillation of spirit or warm perchloride solution.

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WEDNESDAY, SEPTEMBER 27, 1905.

A POLICY OF RESIGNATION.

THE second of the series of articles which are appearing in our columns on the future of the Irish Medical Association is from the pen of Dr. R. B. Mahon, of Ballinrobe, a prominent member of the Association, and the practical founder of the Co. Mayo Branch. With a freely running, but somewhat sarcastic, pen the writer has drawn a picture—we fear an accurate picture—of the many factors which contribute to the failure of the Association to do its work and to accomplish the ends for which it was created, and he concludes by suggesting a remedy for the present condition of the Poor-law Medical Service. Reduced to syllogistic form Dr. Mahon's remarks may be expressed as follows:—The members of the Poor-law Medical Service say that the conditions of the Service are wrong and call for immediate reform. The members of the Poor-law Service have it collectively in their power to compel the carrying out of any reforms the members wish. Therefore. the Poor-law Service can at any time be set right. But there is an alternative to be considered. Are the conditions of its service really unsatisfactory? "Are you really contented with your lot or not?" asks Dr. Mahon. "Are all these statements, instances, opinions, we have heard, merely Irish high-falutin'?" This alternative is dismissed, we think rightly, for there can be no question but that reform is necessary, and then Dr. Mahon proposes his policy. Shortly put, it is, as he tell us, that of the virtuous nobleman, who, imprisoned in a castle without food or drink for twenty years, was at last driven to despair, and opened the door and walked out. Here, says, Dr. Mahon, is at least a definite policy. The Poor-law Service denies its servants meat or drink, pension or vacation, let them step out of its ranks, and return again on their own terms. In other words, his policy is denoted by the heading of this article—a Policy of Resignation. Now there are two kinds of resignation: resignation to our lot—a good policy if our lot is a good one; and resignation of our lot—a good policy if our lot is a bad one. There will be many to say that, since "we doctors are timid folks like the rabbits," a policy of resignation of the former kind has long been adopted, and that but for it the Poor-law Service would not be as it is. This is perhaps true, but it is a policy of another and very different kind which Dr. Mahon suggests. Begin, he says, with a plain and temperate statement of grievances to the Local Government Board, and with a programme of amendment, and if to this the Board returns an answer of *non possumus*, arrange a proper legal plan of wholesale resignation after a conference with all concerned. The policy is a taking one. It is so simple, so obvious, and so efficacious, if properly carried out, that at first sight it almost makes one overlook its inherent impossibility in the present condition of things. To carry it into effect a united profession, an Association loyal to itself and to the least of its members, and a settled confidence in the loyalty of its members to each other are preliminary. Have recent events tended to foster the belief in the possibility of creating afresh these essentials? We fear not. Rather have cliques and factions been created which never existed before. Such a scheme as that proposed means, if carried into effect, that every man must come into his own again, and that any effort to supplant an existing officer must be met by the forces of the entire profession; for in such a scheme, though men may be prepared to sacrifice themselves for the public good, they must not be asked to do so on account of the want of chivalry—to call it by no worse a term—of a professional brother. Could the Irish Medical Association in its present state make itself responsible for this? Then, for such an undertaking, a war-chest is necessary to meet the thousand-and-one expenses that would have their claim on the Association funds. Could the latter stand the strain? They have of late been so frittered away in frivolous and even illegal expenditure that it may well be asked, "Where are they?" Dr. Mahon in part recognises this, and, as a preliminary to the adoption of his policy, calls for a united profession and a solid Association. It is here the difficulty lies. He asks if his scheme is Utopian. The answer is obvious. The scheme is far from Utopian, it is simplicity itself; but, with the history of the past year before us, it is Utopian to expect the realisation of the antecedent and necessary conditions.

BILE BEANS IN THE LAW COURTS.

The Scotch correspondence columns in our issue of September 20th contained a summary of the chief points in an action brought by the proprietors of a much-advertised quack remedy—"Bile Beans"—to interdict an Edinburgh chemist from selling a substituted article under that name. The judgment of the Lord President forms a scathing comment on the methods of patent medicine vendors. It has so wide and suggestive a value, that it will be of interest to review some of the points brought to light in the course of this remarkable trial. It appears that nine years ago one of the complainers—as they are called in Scotland—Gilbert by name, was a printer in Australia. He was 21 years of age when he joined the second complainer, Charles Fulford, who had been engaged for five years as an unqualified assistant in a chemist's shop. With this scanty basis of scientific knowledge, the two started "Gould's Tiny Tonic Pills," a venture which, however, failed. In the year 1899 Fulford had an inspiration which revealed to him the title of a new pill, namely, "Bile Beans for Biliousness." The pill caught the fancy of the public both in Australia and in the United Kingdom. In a comparatively short time it commanded an enormous sale, as may be gathered from the fact that no less a sum than £300,000 was spent in advertisements. The pills for some time were made for the complainers by a well-known American firm, which was stated to have held in stock at the time when the contract ceased no less than thirty-one million "beans." The advertisements were drawn up in an artful and alluring form. They stated that Charles Forde, an eminent scientist, had thoroughly investigated the healing extracts and essences of Australian roots and herbs, and that after prolonged search he had found "a natural vegetable substance, which had the power of acting on the human system in the same way as Nature's own animal substance, bile, and which was beyond all doubt the finest remedy yet discovered for all liver and digestive orders." This statement the Judge stigmatised as false and fraudulent. There was no such person as Charles Forde, his true name being Fulford; he was not an eminent scientist, having had no scientific training and no standing whatever as a chemist or anything else; he never investigated the healing extracts and essence of Australian roots and herbs; he never made any research, he never was the discoverer of a natural vegetable substance which acted like animal bile. In fact, no such substance existed, and no such substance formed any part of Bile Beans, which were compounded by wholesale chemists in America out of drugs which they had in stock, no one of which had anything specially to do with Australia. In short, this judgment tore the whole of the complainers' case to shreds and tatters. His lordship stated in so many words his opinion that their business was founded entirely on fraud, impudence, and advertisement, though it might be that the pill was as effective as any ordinary pill compounded to act as a cholagogue or ordinary laxative medicine; but it seemed certain that these beans would never have taken hold of the public as they had done except for the foundation fiction of their being the product of a "Great Discovery of an ancient Australian Medicine by an Eminent Scientist, using the most scientific methods and apparatus." He therefore dismissed the action, on the ground of these frauds. This case, it will be observed, does not prevent patent medicine proprietors from making false statements about their nostrums; it simply prevents them from prosecuting imitators. The original fraud, therefore, remains active, only that the profits therefrom go to an unscrupulous imitator instead of to the original rogue. The public, as so often happens with British law, is not protected by this decision. The case, however, is of value inasmuch as it will to some extent curb the exuberant falsehoods of the patent medicine man, who is one of the most unscrupulous vampires that batten upon the community. The fact that enormous fortunes can be rapidly accumulated by extravagant claims advanced on behalf of a simple aperient pill forms a bitter satire upon the laws no less than upon the common-sense of the nation. Lord Ardwall hit the nail upon the head when he said that Bile Beans might be as effective as any other laxative medicine. The public, however, apparently prefer buying Bile Beans at a fancy price instead of excellent aperient pills, compounded of the purest drugs by the best makers, which may be bought wholesale at less than a shilling a gross. The fact that £300,000 have been spent in advertising the fraudulent article furnishes the key to the position. When vast sums of that kind are in the air newspaper owners are not likely to examine too closely the statements they are asked to publish in their columns. There must, nevertheless, be some way out of the wood, and there is little doubt that it would readily be discovered were more of our lawyers and legislators of the strong common-sense and outspoken type of Lord Ardwall. An evil of the kind in question is one which the medical profession should be fully informed on and be prepared to speak emphatically when occasion arises. In all probability the most effective step would be that adopted in Germany, namely, the compulsory publication of the ingredients on an attached label outside every medical preparation sold to the public as a proprietary article. Meantime the Bile Beans fraud constitutes an admirable reference case for future reformers.

"RETURN" CASES.

A LONG and important report on the occurrence of so-called "return" cases of scarlet fever and diphtheria has been published by the Metropolitan Asylums Board, and the matter it furnishes and the deductions drawn will probably give rise to much discussion. We congratulate the Board on its policy of firmly facing this vexed question. and not allowing it to drift into the sphere of those "acts of God" which, however dear they may be to the hearts of theologians and lawyers, should have no place in epidemiology. In 1898 Professor Simpson was appointed for six months by the Board to investigate all alleged "return" cases following the discharge of patients from their fever hospitals, and in due course a report was presented. Its chief importance lay in the evidence it furnished of the infectivity of mucous discharges from the ears and nose, and the absence of evidence of the infectivity of desquamation—facts which had for some time been shaping themselves in the minds of medical men connected with fever hospital administration. Otherwise the report was meagre, and it is well that the Board decided to adopt its final recommendation that the enquiry should be pursued still further. Dr. Cameron, one of its own medical officers, was accordingly appointed, but he appears not to have begun his investigations till eighteen months after Professor Simpson's ceased, and to have completed them in thirteen months. Incidently it is a matter for surprise that Dr. Cameron should speak in the preface to his report of his investigations lasting from July 1st, 1901, to July, 1903, and in the next clause of the preface say that the period covered by the report extends from July 1st, 1901, to July 31st, 1902. Does this mean that Dr. Cameron took a whole year to write his report? If so, we can find no excuse for the ambiguity and incorrectness of much that it contains. The value of the report must be held to lie chiefly in the facts presented, for the arguments founded on them and the recommendations derived from the arguments must be judged on their own merits. As a matter of fact, the report was submitted to ten medical superintendents of the Board's hospitals for comment before publication, and their criticism is appended. We may say at once that this criticism, courteously worded as it is, acutely traverses much that Dr. Cameron puts forward, and is of higher value than the body of the report itself. It is impossible, in the limits of a single article, to do more than detail some of the more important conclusions and recommendations, although there is ample scope for criticism of both the method of using the figures accumulated and the deductions drawn from them. For instance, it is incomprehensible that when on investigation Dr. Cameron was able to satisfy himself that 155 of the 688 alleged return cases were not actual return cases, but had been infected from other sources, he should have continued to include them in his figures, and thereby discounted his argument. How is it possible to speak of the "infecting" case in connection with a "return" case, when it is known that the return case had been infected from another source? But though the report is vitiated by blemishes such as this, we find that it contains a good deal of interesting information, and though this information presents no particular feature of novelty, it helps to establish propositions that were in some dispute. For instance, we take the actuality of the condition known as scarlatina *sine eruptione* to be pretty definitely testified to by a list of cases that occupies fourteen pages of the report. All of these happened in association with outbreaks of declared scarlet fever, and were for the most part characterised by fever, sore throat, glandular enlargement, and digestive disturbance. Most of the patients were adults or elder children, and in some cases they seem to have infected the younger ones with well-marked scarlet fever. Then, too, we notice that the infectiousness of rhinitis is abundantly shown, and still more so that a patient may develop an infectious discharge from the nose after he has left the hospital apparently well. It is a matter for regret that such an expression as rhinorrhœa is repeatedly used as a conclusion, when, after all, it is but the name of a symptom. The occurrence of rhinorrhœa after or in convalescence from scarlet fever is, of course, exceedingly common, but it must depend on an inflammatory condition of the mucous membrane of the nasal passages or the naso-pharynx. To dismiss a case as infectious because it has rhinorrhœa, or to argue, as is done at great length, about the period of the patient's detention in hospital, seems to us to beg the question. If a morbid condition of the nose or naso-pharynx is present it should be attacked, and the patient detained till the cause has been effectually dealt with. In the light of modern knowledge, it is astonishing that the presence of adenoids, which is probably the cause of most of the cases of "rhinorrhœa" after scarlet fever, is only mentioned once in the 688 cases, and then only incidentally. Surely if naso-pharynx were systematically examined and cleared of adenoids we should hear far less about "rhinorrhœa" and return cases. Another fact that is brought into strong relief is the enormous length of time to which detention of scarlet fever patients in hospital has spun out. The Park Hospital keeps its patients seven and a half weeks, which is a week less than any of the other institutions, whilst the average for the whole of the Board's hospitals is 64·5 days, and in one hospital—the South Western—the period of detention reaches the staggering figure of 71·6 days! With regard to diphtheria, as was to be expected, the rate of return cases is much lower than in scarlet fever, but it is disconcerting to discover that in 55 out of a total of 142 "return" cases of diphtheria, the original or "infecting" case had been in a Board hospital not for diphtheria at all, but for scarlet fever! If any further evidence were needed to show that the time is ripe for a public inquiry into the utility of scarlet fever hospitals to the community, we think this report will supply it, for it is recommended that further sums should be sunk in building operations with a view to experimenting as to whether complete isolation of each patient would be desirable.

Notes on Current Topics.

County Medical Officers of Health.

It would seem to be merely in acordance with the dictates of common-sense that public bodies charged with the supervision and administration of sanitary Acts should have at their disposal an adviser who knows something about sanitation. Important as this is for local authorities, it would seem to be even more so for those whose duty it is to collect and collate their work, and to bring it all into unison. Yet the County Councils, the supreme health authorities for the districts under their control, have yet but dimly appreciated their duties. Several important counties have of course appointed medical officers, at fairly good salaries, but there is still a majority who prefer to blunder along as best they can, rather than find £600 or £800 a year for an expert adviser. An amusing and undignified performance has just been gone through by the Somerset County Council. Having made up their minds to have a medical adviser, and wishing to spend as little as possible, they advertised for a part-time medical officer, who was to do all that they wanted for the handsome remuneration of £150 a year. However, they received several applications and finally selected a candidate for election. We do not know what rules of procedure guide the doings of the chosen representatives of the Cheddar county, but before proceeding to the election, a resolution was proposed, seconded, and passed that they would not have a medical officer at all! The only satisfactory feature about this absurd *volte face* is that the chairman of the Sanitary Committee promptly resigned.

Dr. Barnardo.

The death of Dr. Barnardo removes from the stage of life a striking figure. Like General Booth, Dr. Barnardo in his time has come in for a good share of criticism, and doubtless it is not possible for a human being to raise and carry on a huge organisation like the Salvation Army or Barnardo's Homes without committing mistakes in method and mistakes in detail. But after all has been said, the fact remains that Dr. Barnardo—the title has become permanently associated with his name, though he never held a University degree—was a man of keen philanthropy and iron resolution. A poor man, without much influence, he started his work among destitute children from sheer kindness of heart, and by untiring industry and equally untiring impartiality—at least in the earlier days of his work—he built up the magnificent organisation which opens its doors to all the poorest children of London, and seeks to turn them into healthy, useful citizens. Dr. Barnardo was one of the first to recognise the potentialities of Canada as a country which could cater for the overplus of the mother-country's population, and not a few of his charges, who but for his care might be inmates of prisons or workhouses, are prosperous and well-conducted citizens in that colony. Although Dr. Barnado's work lay chiefly outside medical circles, it would ill-become his profession to withhold their admiration from his noble and untiring efforts on behalf of the poor.

Rat Destruction.

THE extermination of the rat on board ships has now become the object of many endeavours, the problem being how to kill the animals without damaging cargoes which may consist of perishable articles or food-stuffs. An apparatus has been invented at Hamburg by Dr. Nocht and Mr. Geimsa which has given such satisfaction, not only by its efficiency for killing rats without injuring cargoes, but also by its economy in working, that the harbour authorities have ordered one for immediate use. By it gas is manufactured by blowing air into a chamber where coke is burning, and from this it can be conducted through the ordinary ventilators into the hold of the ship, and removed from it after diffusion is complete. The heat generated by the coke is used to pump up water to cool the gas as it is formed, and also to work the ventilator that drives the air into the chamber. By this means great economy in working is attained. Moreover, the steam can at the same time be utilised for disinfecting purposes in an ordinary chamber alongside, and by mixing it with formalin vapour as it passes to the hold the cargo can also be disinfected if desired. Experiments have been carried out by using the "producer" gas to kill rats confined in the holds of vessels, and it has been demonstrated that even when the cargo is loaded, the rats are found out and killed by the gas. *Post-mortems* show them to have died by carbon-monoxide poisoning. It is anticipated that the apparatus will be largely used by port authorities.

Wanted—Bugs!

THE irreverent student of the natural sciences takes a delight in affixing a picturesque and complimentary terminology to the objects of his studies, and bacteria have been known as "bugs" ever since the science that deals with them was evolved. At a different stage of his career, however, the student, when he assumes the bag and sallies forth to help the labouring motherhood of his district, makes acquaintance with the real article in grim earnest. He learns then, probably for the first time, the extent to which prevarication can be carried, for the poor woman, be her home never so filthy, has always an exclamation of surprise and an explanation of a sort to proffer for the inevitable bug, with whom she must long have made her bed, and known as well as she does her children. It will readily be understood, then, that Liverpool is roused to indignation by an advertisement emanating from the School of Tropical Medicine, and offering a halfpenny apiece for five hundred uninjured specimens of *Cimex lectularius*. It is not aversion to the experimental methods of the school, or tender-heartedness for the welfare of living creatures that has aroused the storm, but the slur that is cast on the character of the town. It is freely alleged that the experimenters will be disappointed, as there is no more probability of five hundred bugs being found in Liverpool than of five just men being found in Sodom. Alas for the pride of the great cotton city! More than the desired number were forthcoming in a day, and since that day the authorities have been simply overwhelmed with would-be caterers of the required insect.

Inoculation of Measles.

IN the *Journal of Infectious Diseases* for March, 1905, there are related by Dr. Ludvig Hektoen, of Chicago, two instances in which he succeeded in inoculating measles. In the first case blood was withdrawn from a boy convalescent from scarlet fever, who developed a mild attack of measles. The blood was placed in ascites-broth and incubated at 37° C. for twenty-four hours, when both the cultures and various sub-cultures made from them were found to be sterile; 4 cc. of the ascites-broth and blood mixture were then injected under the skin of a young man who had just recovered from scarlet fever. Thirteen days afterwards the temperature rose to 101° F., and on the fourteenth a blotchy, red, papular rash appeared on the forehead. This quickly spread to the face, neck, and chest, and in two days had assumed the well-known appearance of a measles rash. The constitutional disturbance was slight; there were no catarrhal symptoms, but branny desquamation followed. The second patient from whom blood was taken was a girl, aged twenty-one, on the second day after the appearance of a typical measles rash. This blood was again inoculated with ascites-broth incubated at 37° C.; it, too, remained sterile. Twenty-four hours after its incubation, 5 cc. of a mixture of the blood and ascites-fluid were injected under the skin of the back of a man. On the eleventh day the temperature rose slightly, and the day afterwards conjunctivitis set in. Sore throat, and cough followed, and on the fourteenth day a well-marked measles rash came out in the ordinary sequence. The patient's temperature was 103° F. at the time the rash began to appear, yet otherwise he suffered but little discomfort, and his recovery was rapid and complete. It is a striking fact that though the blood withdrawn from the patients must have contained the virus of measles, no bacteria could be cultivated from it in the various media used.

Medical Examination of Merchant Seamen.

THE present is an age of thoroughness, demanding evidence of competence in mind and body in all public capacities. The service of the merchant ships of the United Kingdom is one of the great pillars of the nation. It is hardly surprising, therefore, that the suggestion has been made that the bodily fitness of sailors should be ascertained by medical examination before they start upon a voyage. Such a regulation has been actually in force for some time past in Germany, but it, of course, does not necessarily follow that it would be desirable for British crews. There can be little doubt, however, that a certain small percentage of merchant sailors are shipped in spite of bodily unfitness, and in that case it goes without saying that an undue share of labour must be thrown upon their sounder mates. It seems more likely that unfitness far oftener consists of absolute ignorance of nautical matters than of unsound bodies. The matter has been taken up by the Scottish Shipmasters and Officers' Association, who are in communication with the Board of Trade. The bearings of the subject will doubtless be fully discussed from every point of view before any official sanction is given to a step that may have somewhat far-reaching consequences.

Venereal Disease in the Navy.

The fact that there is a daily average in the home ports alone of from six to seven hundred sailors and marines under treatment for venereal diseases is a matter of importance to the taxpayer. He has a right to ask and to know whether all possible steps are being taken by the naval authorities to prevent a loss to the public service of something over three hundred thousand days' work every year, and it is to this question Dr. Philip Randall, formerly of the Royal Navy, devotes himself in the current number of the *Practitioner*. Dr. Randall argues with much force that in the home ports the men themselves are the principal propagators of the disease, and that an efficient system of quarantine would go far to limit its spread. At present the average time of each patient under treatment for primary syphilis is only thirty days, and for secondary syphilis thirty-five days. At the end of his period of treatment the sailor returns to his ship, and the surgeon has then the power of imposing a quarantine of eight days. There is no further control over him until he again reports sick. This period of treatment falls far short of the standard of two years usually adopted in civil practice, and it is absurd to think that it is sufficient to effect a cure. Dr. Randall suggests that each patient returned to his ship after treatment for venereal disease should be kept in quarantine, with periodical medical examination, for a prolonged time. During the whole of this period he should be strictly confined to bounds, and any breach of quarantine should be a gross offence against discipline. The difficulty of adopting such a plan is that its rigour may defeat its own object by inducing men to conceal their condition. All must agree, however, that the present method is insufficient.

Mushroom Poisoning.

The daily papers during the past few weeks have contained reports of many cases of mushroom poisoning of more or less gravity. This, of course, occurs every year during the season, but in the present year, doubtless owing to the rich mushroom crop, more misadventures have fallen to be recorded than is usual. It is said in some districts the crop was so large that numbers of dwellers in the towns—ignorant of things pertaining to the country, were engaged in picking. It is probable that to the ignorance or carelessness of such people are due whatever misadventures have taken place. It is not in the experience of many medical men to have attended cases of fungus-poisoning, but nevertheless the symptoms, taken with the history of having eaten mushrooms, are not likely to give rise to any error of diagnosis. The poisonous fungus which in most cases is eaten in mistake for the mushroom is the *Amanita phalloides*, and the active principle is the toxalbumen phallin, which presents many points of resemblance to ricin and abrin. The most common symptoms are diarrhœa and vomiting, pain and cramps in the stomach, thirst, and in the most severe cases collapse, with cold sweating, delirium, and suppression of urine. Ten or twelve hours usually elapse before any symptoms are noticed. The *A. phalloides* is easily recognisable by its greenish-yellow top, its permanently white gills, and the fact that it rarely grows far from trees. There is no specific antidote for phallin, and the treatment adopted must be such as is proper in other cases of irritant poisoning.

Industrial Mercurial Poisoning.

The Medical Inspector of Factories has recently issued an important memorandum relating to the occurrence of mercurial poisoning as a result of employment in certain industries. Medical men attending cases of mercurial poisoning contracted in any factory or workshop are now required to notify them to the Chief Inspector of Factories. It is interesting to learn that the silvering of mirrors is no longer done by means of mercury and tin amalgam, but by the nitrate of silver and ammonia process, with the result that what was formerly a prolific source of mercury poisoning is no longer operative. The occupations which most commonly give rise to mercury poisoning are enumerated. Of these, apart from the manufacture of thermometers and barometers, and of mercuric compounds, the most important is technically known as "carotting." This is a process in the furrier's trade, in which rabbit-skins in course of preparation are washed with a solution of acid nitrate of mercury. Of fifty-six attacks of mercuric poisoning arising from industrial employment, reported between May, 1899, and December, 1904, the distribution was as follows :—Thermometer-making, 15 ; electrical meters, 15 ; hatters' furriers, 10 ; chemical works, 7 ; water-gilding, 5 ; powder factories, 3 ; photo engraving, 1.

Sanatoria for the Working Classes.

The Hospital Saturday Fund has decided on a great enlargement of its sphere of activity in starting a national movement for the establishment of sanatoria for phthisical patients of the working classes. The intention is, we believe, to attempt to build and equip sanatoria throughout the country, which should thereafter be self-supporting. As the first step towards the realisation of this scheme, a site for a pioneer building has been secured at Benenden, in Kent, and an appeal issued for £50,000 to erect a hospital capable of housing two hundred patients. It is stated in a letter to the public papers, signed by the Princess Christian as president of the Special Appeal Committee, "that the various societies and trades unions guarantee the cost of maintenance, but under the terms of their constitution they can only make small donations towards the building and purchase of land. The sanatorium, therefore, will be self-supporting, and no appeal for funds will ever be made to the public again." We have no doubt the sum required will be forthcoming, and if the promise of no further appeal be kept, it certainly deserves to be. If the Benenden sanatorium prove a success for London, other cities will, of course, be likely to follow the example. Though such movements as this appear absurdly small in regard to the evil they have to meet, it is not to be forgotten that the anti-tuberculosis movement has, up to the present, reduced the mortality from the disease in England by about two-thirds.

Nostrums and the Lay Press.

IT is satisfactory to learn that many of the better-class lay papers in the United States are waking up to a recognition of the impropriety of the alliance which has so long existed between newspapers and the proprietors of nostrums and patent medicines. The drug evil has been, if anything, more serious in America than on this side of the Atlantic, and the exposures of the nostrum trade which have been made in the *Ladies' Home Journal*, and more recently in *Collier's*, came none too soon. It is, of course, too much to expect that a similar course may be followed by some representative English journals. The refusal to admit to advertisement columns even those quack remedies which could be easily demonstrated to be fraudulent would mean a loss of income which our society and religious press is not likely to inflict on itself. It is often thought that the opposition of the profession to quackery is based on self-interest, but nothing can be farther from the truth. Were we merely acting in order to increase our professional work, we should do our best to increase self-drugging, as a means of injuring the public health. The evils of nostrum-dealing, however, are by no means wholly physical. The more serious evil is the social and moral one involved in the maintenance of a class of swindlers, for it is to be remembered that the man who exploits "a certain cure" for any disease is as much a social parasite and a common cheat as is a card-sharper or a pickpocket.

An Anatomical Windfall.

AMERICA, the land of inexhaustible surprises, has furnished a recent instance of an eccentric legacy to a medical school. The will of General Isaac J. Wister, of Philadelphia, who died a few weeks ago, left various things of scientific and financial value to the Wister Institute of Anatomy and Biology. He bequeathed his brain to the Institution, which will for future ages enjoy the undoubted privilege of displaying the brains of its founder to all and sundry. In addition, he gave his right arm to the curators as a desirable specimen of gunshot ankylosis. We do not gather, however, that the organ previously mentioned was deemed worthy of preservation upon pathological grounds. Whatever educational interest these relics may possess they are likely to be far outweighed in their value to posterity by the munificent gift by the testator of the bulk of his fortune, estimated at two million dollars, to the Institute. Science on this side of the Atlantic is not often endowed on this gargantuan scale. It is likely that our great medical corporations would accept bequests of the kind even if handicapped by gruesome additions of the testator's bodily frame to be preserved in perpetuity.

The Diminishing Birth-rate in Kensington.

THE question of the steadily falling birth-rate of the United Kingdom is clearly of great importance to the national welfare. Since general attention has been called to the subject, the reports of medical officers of health often teem with instructive and valuable facts. The last report on the Borough of Kensington illustrates in a remarkable manner the influence of wealth and environment upon the increase of population. The district in question includes a wide area, with sub-divisions, some of which represent rich quarters and others those of poverty. The total birth-rate has declined from 33·1 per 1,000 persons living in 1868 to 19·3 in 1904. North Kensington includes some poor quarters, and there the birth-rate was 27·1 per 1,000 living, or 0·8 below the rate for the whole Metropolis. In wealthy South Kensington, on the other hand, the birth-rate was 11·0, or 16·9 per 1,000 below the metropolitan average. Notting Dale is a crowded and poverty-stricken special area under the jurisdiction of the Kensington Medical Officer of Health. The birth-rate for 1904 in that sub-district was 28·2, against a death-rate of 36·2. It will be seen, therefore, that Kensington presents in three parts of its area such widely different birth-rates as 11·0, 27·1, and 28·2 per 1,000 living.

Cancer and the Poor-Law Cold Bath.

THE story of Oliver Twist in his suffering childhood's days spent in a pauper school embodied a fierce satire upon Bumbledom, as it existed in the days of Charles Dickens. There still remains plenty of work at hand for the social reformer. A single instance will suffice to show the cruelty of our iron-bound official system. A woman of fifty was recently hauled before the magistrates and sent to prison because of some dispute with the attendant in the receiving-room of a workhouse. This poor woman, according to her own statement, was suffering from cancer, attended with hæmorrhage. She was, however, forced to strip and plunge into a cold bath. The inhumanity of such a proceeding, accepting the facts as stated, is of the kind to make angels weep. The picture of a middle-aged working-class woman afflicted with a terrible internal malady being thrust into a cold bath sounds like some fiendish Chinese torture instead of an official custom of Christian England in the twentieth century. There was no attempt on the part of the prosecuting authority to deny the unfortunate woman's statement that she was suffering from cancer. Surely if she made such an assertion on admission it was the duty of the workhouse authorities to have her case reported upon medically before putting her into a cold bath. It may be necessary to wash persons entering workhouses, but any rule to that effect should be elastic, and in cases of illness be administered only with the sanction of a medical officer. Why should not workhouse baths in winter be warm or tepid? The object is, or should be, to cleanse, and not to shock and injure sick and weakly applicants.

Medical Teaching, Metropolitan and Provincial.

THE London medical schools are gradually awaking to the fact that they are being outstripped in the race with their provincial rivals. The extra-metropolitan Universities have provided for a long-felt want by granting the degree of M.D. on reasonable terms. As a consequence of this prudence they are diverting more and more students from London every year. Nor do the provincial Universities and schools of medicine fail to furnish first-class teaching and first-class facilities of all kinds for scientific and practical studies. Yet it is only within a year or two that London has possessed a teaching University. Its standard of medical examination still stands so high as to be prohibitive to the average student. Time alone will show whether the provincial graduate will compare favourably in the later battle of life with his London brethren. It certainly seems a pity that in spite of a boundless field of clinical material in the Metropolis the practical bedside experience gained in some of its schools nevertheless falls short of the provincial schools. The most likely explanation appears to be that there has been hitherto a disproportionately large number of London students in relation to beds. In some of the largest and most popular provincial hospital schools, however, precisely the same thing happens. It may be questioned whether our scheme of medical education generally would not profit by being rendered more practical and less academic. The true test of the fitness of the newly-fledged practitioner lies in his ability to meet all the ordinary emergencies of general practice. A conspicuous instance of the failure of our present system was proclaimed to an astonished world not long ago when a house surgeon was actually unable to perform a tracheotomy upon a patient brought to his hospital. The medical man in charge of the sufferer afterwards gained great praise for his courage and skill in opening the trachea! If the end of medical education and qualification be to turn out alert and competent practitioners, it is interesting to ask what is the moral of the foregoing incident.

PERSONAL.

THEIR Majesties the King and Queen have telegraphed expressions of sympathy to the friends of the late Dr. Barnardo.

H.R.H. PRINCESS CHRISTIAN paid an unofficial visit to the Aberdeen Royal Infirmary on Saturday last, and was shown over the Institution by some of the Governors and members of the medical staff.

MR. JAMES FIDLER, of Gower Hey Bank, Hyde, Cheshire, has left £1,000 each to the Manchester Royal Infirmary, the Ashton-under-Lyne Infirmary, and to the Mayor of Hyde for the benefit of the poor, and £500 to Henshaw's Blind Asylum.

MR. JOHN THORN, of 11, Miles Road, Clifton, bequeathed £100 each to the Infirmary, the General Hospital, and the Children's Hospital, Bristol, and £100 to Muller's Orphanage.

DR. T. W. SMARTT, the Cape Commissioner of Public Works, opened the De Aar-Prieska Railway last week.

THE medical profession have unanimously nominated Dr. Reeve, Dean of the Medical Faculty of Toronto University, for the presidency of the British Medical Association at its meeting in Toronto next year.

MR. JOHN BLAIR, M.D.R.U.I., honorary assistant surgeon to the Royal Albert Edward Infirmary, Wigan, and Mr. George Wolstenholme, M.B., C.M.Glasg., have been appointed magistrates for the county borough of Wigan.

THE following is the list of candidates for the Chair of Midwifery in Edinburgh University, rendered vacant by the resignation of Professor Simpson:—J. W. Ballantyne, M.D., A. H. Freeland Barbour, M.D., Sir J. Halliday Croom, M.D., James Haig Ferguson, M.D., William Edward Fothergill, M.D., F. Berry Hart, M.D., F. W. N. Haultain, M.D.

DR. W. M. MUAT, of the Medical Department of Northern Nigeria, has resigned his appointment on the ground of ill-health.

DR. F. J. WALDO, Coroner for the City of London and Southwark, has been placed by the Lord Chancellor on the Commission of the Peace for the County of London.

SIR LAUDER BRUNTON, who was on his way home from the Congress of the British Science Association, has been detained at Cape Town, in consultation with Dr. Sinclair Stevenson, of Rondebosch, in the case of the late Colonel Rhodes. He will in consequence not reach London until October 7th.

DR. WILLIAM OSLER, Regius Professor of Medicine, Oxford, has promised to address the members of Guy's Hospital Physical Society on Thursday evening, October 12th, the subject being "Sir Thomas Browne and His work."

THE International Congress on the Education and Household Management of Infants commenced last week at Liége.

Correspondence.

THE QUACK MEDICINE TRADE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The revelations as to the composition and qualities of "Bile Beans," and the history of the proprietors, made recently in the Scotch Court of Session, and reported in your issue of September 20th, will cause no surprise to any medical man, who at the same time has the least claim to be styled a man of the world. The exposure merely adds a little more unimpeachable testimony to the mass of evidence that already exists as to the injury to the public health which the vast traffic in useless and harmful nostrums is inflicting. The case for legislation in this matter is overwhelmingly strong, but it needs making clear and bringing home to the minds of the educated public and of our law makers. The way to do this is through the medium of a Royal Commission. If the united profession would take the proper steps to obtain the appointment of such a Commission to examine into the question, not only of the trade in quack medicines, but into the practice of medicine for gain by unqualified persons, there can be little doubt they would succeed. The evidence would prove the urgent need for reform of medical law—reform which will never be conceded while it is looked upon as a trades union demand by the profession for their merely selfish ends.

I am, Sir, yours truly,
AN OBSCURE PRACTITIONER.
September 21st, 1905.

Literature.

THE PREPARATION AND MOUNTING OF MICROSCOPIC OBJECTS. (*a*)

AT first sight one is not likely to be impressed with this book, as the common class of binding, paper and printing are not such as a student likes to see in a book which is to be in constant use. The printing especially is of a character very tiring to the eyes. A careful perusal, however, reveals the fact that the "get up" is far from worthy of the contents. The combined efforts of Mr. Davies and Dr. Matthews have produced a volume which will, we are sure, prove most useful to the medical student, to the practitioner, and all who make slides of microscopical objects whether for professional use or for amusement. In order to make the book acceptable to the profession, a chapter dealing partly with elementary histological manipulation, together with other matter has been added. The descriptions of processes are given with a most agreeable lucidity, and in those cases where the authors are not speaking from personal experience they frankly acknowledge the fact. The diction of the letterpress is of a style which is pleasantly refreshing after the cut-and-dried style of the average text-book,and altogether we have a most favourable impression of the work, as the aim of the authors has obviously been not to write a book, so much, as to be of service to beginners in this most interesting science at which they themselves are adepts.

MEDICAL CHEMISTRY AND TOXICOLOGY. (*b*)

THE author first takes a preliminary glance at the subject of physics, so far as is necessary to refresh the student's memory and not to teach him, as the is presumed to have acquired a substantial knowledge of the subject before entering the medical college. The author seeks to teach the subject of chemistry in the way that a medical man should know it, and for this reason omits many things which he would have included, had the work been intended to be a textbook of pure chemistry, as he truly says, "A due sense of proportion requires much teaching of the essentials of medical chemistry and avoidance of extraneous matters which, at this stage only complicate a study sufficiently difficult in its simplest form." The various elements and compounds are treated in a way that is most satisfactory and with each account of the various substances where such are poisonous, the symptoms, fatal dose and period, treatment, post-mortem appearances and detection of the poison are interpolated. This portion of each chapter in particular is very well written, and much more so than in many books on toxicology alone. We expect that the student will greedily devour this portion of the subject, before attempting to master the properties of the substance under consideration, the author having treated of an interesting subject in a highly interesting way. There is one point from which we venture to dissent, and that is when we are told "There is no medical fact better established than that the amount (of copper) necessary to give the attractive colour (to peas) is absolutely harmless." True the author gives his authorities for this statement, but equally high authorities hold the contrary view, and the researches of Tschirch and others are of too definite a character to be thus discounted. The author goes on to say : "No symptoms of poisoning are found in certain copper workers, who show copper as a purplish or bluish line on the gums, whose hair turns green, and whose urine stains the ground green. 'The contention that there is no chronic copper poisoning in men or animals is at present uncontradicted.'" We are glad to hear coming from the other side of the Atlantic the statement : "Even in the small amounts required for preserving cream and butter, and that used as an external dust on hams or bacon which have to be transported long distances, both boric acid and borax are objectionable from a sanitary standpoint, unless the food substances are frankly labelled as preserved." The author remarks in a rather lofty tone what we venture to think is scarcely true, at any rate in this country, whatever it may be in America: "The presence of nitrates and nitrites is no longer regarded as evidence against the purity of a water." The sections of the book on Organic and on Physiologic (*sic*) and Clinical Chemistry are on the whole satisfactory, and it is evident the author has spared no pains to make his work as useful as possible to those for whom it is written, and except in a few cases, such as we have mentioned, where we are at variance with Dr. Holland in matters of opinion, the book is to be commended.

ENCYCLOPÆDIA OF PRACTICAL MEDICINE. (*a*)

ENGLISH readers will welcome this volume of Nothnagel's Practice which places at their disposal, in their own language, the valuable articles on diseases of the blood by such distinguished writers. The volume before us contains five articles, the first of which by Professors Ehrlich and Lazarus deals with the histology of the blood, normal and morbid. We first have an interesting description of the clinical methods of the examination of the blood and then details as to its morphology. As the Editor tells us in the preface the book is not intended to take the place of text-books of clinical hæmatology, and so we have merely a review of those methods in general without any detailed description as to the way in which they should be carried out. This omission may appear to some to detract from the value of the work, but in our opinion it is a decided advantage, since it is not to such a work that one would naturally turn if one wished to study practically the normal or morbid histology of the blood.

The section dealing with anæmia by Drs. Ehrlich

(*a*) "The Preparation and Mounting of Microscopic Objects." By Thomas Davies. New Edition edited by John Matthews, M.D., F.R.M.S Pp. 214-vi., with five Illustrations. Price 2s. London. C. Arthur Pearson, Ltd. 1905.

(*b*) "Text-Book of Medical Chemistry and Toxicology." By James W. Holland, A.M., M.D. Philadelphia. W. B. Saunders and Co.

(*a*) "Nothnagel's Encyclopædia of Practical Medicine." English Edition. Diseases of the Blood, by Prof. D. F. Ehrlich, Prof. K. von Noorden, Dr. A. Lazarus, and Dr. F. Finkus. Edited with additions by Alfred Stengel, M.D. Authorised Translation from the German under the editorial supervision of Alfred Stengel, M.D. Philadelphia: W. B. Saunders and Co. 1905. Pp. 714. Illustrated. Cloth, 21s. net.

and Lazarus contains three main divisions, each of which are considered separately. These divisions are Acute Post-Hæmorrhagic Anæmia, Simple Chronic Anæmia and Progressive Pernicious Anæmia. Simple Chronic Anæmia is discussed under the following etiological heads:—(1) After frequently repeated hæmorrhages; (2) as a result of continued malnutrition; (3) associated with, and as a result of, other diseases; and (4)after acute and chronic intoxications. A study of the opinions advanced in this section of the work will not tend to make any one very boastful as to the great advance of our knowledge in the science of hæmatology, and most readers will agree with the authors that though "on account of the close metabolic relations which the blood bears to all the organs of the body there is scarcely a pathologic process of any extent without the blood showing some manifestation. Still, the anticipation has not been fulfilled that definite changes in the composition of the blood would be found corresponding to definite diseases, thereby aiding both diagnosis and prognosis."

In dealing with progressive pernicious anæmia the authors follow the definition of that disease given by Biermer and subsequently amplified by Ehrlich; they do not look on it as "a disease *sui generis*, but a frequently occurring syndrome arising in connection with very different affections." It is still a very doubtful question whether this is the correct attitude to adopt, and we question very much if it will meet with general acceptance in this country. The work of Hunter may be, as the Editor tells us, still unconfirmed, but his hypothesis appears, at all events, to have much to justify it from a clinical standpoint.

Von Noorden contributes a long and very interesting article on chlorosis, and advances the hypothesis that this disease is due to "disturbances of blood-formation which proceed from the sexual organs." In regard to the treatment of chlorosis he maintains a firm belief in the value of iron which he explains in the following way. "The salts of iron circulating in the blood (medicinal iron) exert a powerful stimulus on the hæmatopoietic cells of the bone-marrow, and the result of this stimulation is an improvement in the quality of the blood. On the contrary, the ferruginous oleo-albumins and the proteids, which gain access to the blood, exert a much weaker stimulus; this stimulus is so slight that the ferruginous nucleo-albumins, which are present in the diet in relatively small quantities, are not sufficient to overcome the sluggishness of the hæmatopoietic organs. In addition to the administration of iron, there are numerous other procedures which also have a stimulating effect on the hæmatopoietic organs, and which consequently prove themselves curative in chlorosis."

The remaining sections of the book are devoted to Lymphatic and Myeloid Leukemia ,which are treated of respectively by Dr. Pincus and Dr. Lazarus.

The translation appears to be well done, though for English readers it is marred by the use of such words as "chemic," "pathologic," and "chlorid." the book is illustrated by thirteen plates, many of which are coloured, as well as by several temperature charts inserted in the text. With each section there is a large bibliography given, but it would seem a pity that the names of the authors refered to are not in each case given in alphabetical order.

LUCAS'S BOOK OF PRESCRIPTIONS. (*a*)

WE would gladly welcome this book if only for its introduction. In this Dr. Latham wisely remarks that the practitioner for lack of knowledge of prescription-writing is "tempted to rely too much on various proprietary mixtures, solutions, compressed tablets, and other forms of factory-made physic." He points out that tablets are often inert and not infrequently pass through the alimentary canal unaltered. "Another serious objection to the use of compressed tablets is the ease with which the public are enabled to indulge in the fashionable practice of prescribing for themselves." He adds, "Nor is it dignified for us to allow manufacturing chemists to dictate the combination or the form of the drugs which we prescribe." We have seldom met with such a true and candid statement of what are unfortunately facts. A book which aims at obviating self-prescribing by the laity deserves to be a success. The plan of the work is simple. The pharmacopœia is systematically considered in alphabetical order, beginning with Acacia and ending with Zinc. Under each drug is given its character, action, dosage, and, where these exist, its preparations. The principal feature, however, is the series of typical prescriptions written in full Latin, illustrating the various combinations into which the particular remedy under consideration may enter. The quantities are given in the terms of the imperial and metric systems, while the necessary directions for the patient are in English. After each prescription the disease for which it may be ordered is definitely stated. Some of the combinations are particularly good, and in many instances deviate considerably from the every day well-worn track.

The remedies considered are not exclusively such as occur in the B.P., but many others are included such as ichthyol, dionin, and protargol. An index of diseases with their appropriate remedies has been appended; and this will serve to suggest, especially to the inexperienced, what to prescribe in any particular case. A very full index to the text is also given. To say that this book will be of the greatest possible service to students is to state but half the truth, for there must be indeed few medical practitioners who would not profit considerably by constantly referring to its pages. It is for want of knowledge of the contents of the Pharmacopœia that so much reliance is placed nowadays on ready-made combinations of drugs. With this book as guide no practitioner has any excuse for ignorance of this essential part of his duties. We commend it most heartily to the attention of our readers, who, we feel sure, will have cause to thank us for drawing their attention to its sterling worth and value as a guide to prescription-writing.

NAKED-EYE ANATOMY OF THE HUMAN TEETH. (*a*)

As an auxiliary to the well-known manuals of dental anatomy and surgery, we feel sure this book will be found of considerable value. It meets a distinct want and fills a gap which exists in all English text-books with which we are acquainted. A thorough knowledge of the normal macroscopic appearances of the teeth and contiguous structures is of the highest importance to every student and practitioner of dental surgery, and it is just this which is dealt with all too shortly in even the best and most specialised works. The photographic reproductions illustrating the bony framework of the jaws, the occlusion of the teeth and temporary and permanent dentition at various critical stages, are excellent, and the outline drawings in Chapters II. and III. clearly illustrate the text. Mr. Constant expresses himself simply and clearly, and by no means least important of all the fount of type used in printing is good and clear.

ATLAS OF PATHOLOGIC HISTOLOGY. (*b*)

THE latest addition to the series of translations of Dr. Dürck's Hand-Atlases is in no wise inferior to its companions. It forms, with the volumes of "Special Pathologic Histology," an excellent compendium of morbid histology. The illustrations, most of which are coloured, are of the quality we have learned to

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(*a*) "The Book of Prescriptions (Beasley). With an Index of Diseases and Remedies." Re-written by E. W. Lucas, F.I.C., F.C.S., with an introduction by Arthur Latham, M.A., M.D., F.R.C.P. Eighth Edition. London: J. and A. Churchill. 1905.

(*a*) "The Naked-eyed Anatomy of the Human Teeth." By Thomas E. Constant. Pp. vi. and 189. Bristol: John Wright and Co. 7s. 6d. net.

(*b*) "Atlas and Epitome of General Pathologic Histology." By Docent Dr. Hermann Dürck, of the Pathological Institute. Munich. Authorised Translation. Edited by Ludvig Hektoen, M.D., Illustrated. Philadelphia: W. B. Saunders and Co. 1904. Pp. 357.

associate with the series. They are not photographs, but artistic pictures of what one actually sees under the microscope. At the same time, they partake enough of the diagrammatic to render the cellular elements readily distinguishable. It is not intended that the study of this volume should in any way replace careful microscopic examination of actual sections, but read in explanation of and as a running comment on a series of slides, it cannot fail to be of great service. It is not intended, of course, that it should replace the study of larger text-books, and of monographs, for those who have time or inclination for such work, and it is necessarily somewhat dogmatic in tone, omitting as much as possible the discussion of diverse views. The translation is, on the whole, fair, though there is in the construction an unnecessarily close following of the original, rendering many sentences tedious and involved.

NEW BOOKS AND NEW EDITIONS.

The following have been received since the publication of our last list :—

ADLARD AND SON (London).
The Crystalline Lens in Health and in Cataract. An Address by Sir Wm. J. Collins, M.D., F.R.C.S. Price 6d.

SIDNEY APPLETON (London).
The Doctor Says—What Does the Doctor Say? Pp. 306. Price 3s. 6d. net.

BAILLIERE, TINDALL AND COX (London).
A Manual of Surgery for Students and Practitioners. By Prof. W. Rose, M.B., B.S.Lond., F.R.C.S., and Albert Carless, M.S.Lond., F.R.C.S. Sixth Edition, Illustrated. Pp. 1,350, with 530 Plates and other illustrations. Price 21s. cloth. Leather 25s. net.
Carcinoma of the Rectum, its Diagnosis and Treatment. By F. Swinford Edwards, F.R.C.S. Pp. 48, with Tables. Price 2s. 6d.

JOHN BALE, SONS, AND DANIELSSON, LTD. (London).
Pharmacopœia and Formulary of the Royal Dental Hospital of London. Pp. 24. Price 1s. 6d. net.

MESSRS. CASSELL AND CO., LTD. (London).
Clinical Methods. By Robt. Hutchison, M.D., F.R.C.P.Lond., and Harry Rainy, F.R.C.P. and F.R.S.Ed. Third Edition. Pp. 634
Hygiene and Public Health. By B. Arthur Whitelegge, C.B., M.D., B.Sc.Lond., F.R.C.P., &c., and George Newman, M.D., D.P.H., F.R.S.E., &c. New and Revised Edition. Illustrated. Price 7s. 6d.
Manual of Chemistry, Inorganic and Organic. By Arthur P. Luff, M.D., B.Sc.Lond., F.R.C.P., F.I.C., and F. J. M. Page, B.Sc.Lond., F.I.C. With 43 Illustrations. Price 7s. 6d.

THE J. B. LIPPINCOTT CO. (London).
International Clinics. Vol. II., Fifteenth Series, 1905. Edited by A. O. J. Kelly, A.M., M.D. Pp. 310.

THE CAXTON PRESS, LTD. (London).
The Bodie Book. By Walford Bodie. Pp. 193. Price 2s. 6d.

J. & A. CHURCHILL (London).
General Index of the Year-Book of Pharmacy and Transactions of the British Pharmaceutical Conference for the Years 1886—1903 inclusive. Compiled by J. Oldham Braithwaite. Pp. 514.
The Apsley Cookery Book, containing 448 Recipes for Uric Acid Free Treatment. By Mrs. John J. Webster and Mrs. F. W. Jessop. Pp. 235. Price 3s. 6d.

HENRY J. GLAISHER (London).
A Plea for the More Energetic Treatment of the Insane. By Charles Williams, L.R.C.P., &c., &c. Pp. 51. Price 1s. 6d. net.

WILLIAM GREEN AND SONS (Edinburgh).
Essentials of Human Physiology. By D. Noel Paton, M.D., &c., &c. Second Edition, revised and enlarged. Pp. 444.

CHARLES GRIFFIN AND CO., LTD. (London).
Clinical Diagnosis. By Rudolf V. Jabsch, M.D. Fifth English Edition. Edited by A. E. Garrod, M.A., M.D. Pp. 602. Price 24s. net.
Smoke Abatement. By William Nicholson. Pp. 256. Price 6s. net.

HENRY KIMPTON (London).
The Medical Diseases of Egypt. By F. M. Sandwith, M.D., F.R.C.P. Part I. Pp. 316. Price 7s. 6d.

MCCORQUODALE AND CO., LTD. (London).
Metropolitan Asylums Board Annual Report for the Year 1904. Pp. 340. Price 5s.

THE OBSTETRICAL SOCIETY OF LONDON.
Transactions of the Obstetrical Society of London. Vol. XLVII), for the year 1905. Part II. for March, April, and May. Edited by Herbert R. Spencer, M.D., and M. Handfield-Jones, M.D. Price 5s.

W. B. SAUNDERS AND CO. (Philadelphia).
Diseases of the Kidneys, Spleen, &c. Edited by James B. Herrick, M.D. Pp. 815. Price 21s. net.
A Treatment of Fractures. By Charles L. Scudder, M.D. Fifth Edition. Pp. 563. Price 21s. net.

SPOTTISWOODE AND CO., LTD. (London).
Minutes of the General Medical Council from January 1st, 1905, to May 27th, 1905. Vol. XLII. Pp. 302.

WOOD, MITCHELL AND CO., LTD. (Hanley).
Guide to Finger Print Identification. By Henry Faulds, L.F.P.S. Pp. 80. Price 5s. net.

JOHN WRIGHT AND CO. (Bristol).
Ambulance Examination Questions. By D. M. Macdonald, M.B. Price 6d.

Obituary.

THOMAS SYMONDS HOWELL, M.R.C.S.ENG., L.S.A.

WE regret to record the death of Mr. Thomas Symonds Howell, who died recently at the advanced age of 82. He had a long connection with Wandsworth, for three successive generations of his family had been medical practitioners continuously for over ninety years. He was educated at Blackheath and St. Thomas's Hospital, taking the diplomas of M.R.C.S. Eng. in 1844 and L.S.A. in 1845. For some 35 years he was medical officer to the Royal Masonic Institution for Girls, and first President of the South-West London Medical Society. He leaves a widow and eleven children, two of whom are medical men.

WALTER MOSES GIBAUT, M.R.C.S.ENG., A.M.S.

AN old member of the Army Medical Service died recently at Surbiton, aged 73, in the person of Mr. W. M. Gibaut. He entered the service as Assistant Surgeon, February 3rd, 1854; became Surgeon, September 22nd, 1863; and retired, October, 1871. He was in the campaign in the Crimea from February to August, 1855, and was at the siege of Sebastopol, receiving the medal with clasp and the Turkish medal.

MR. THOMAS J. BARNARDO, F.R.C.S.ED.

THE popular nature of the life-work of this gentleman renders it unnecessary in the columns of a medical journal to do little more than to place on record his death last week from angina pectoris, as the whole press of the country is teeming with eulogies of this distinguished member of our profession, of his life, its purpose, and its successes in the cause of humanity. Our deceased *confrère* set himself a task, the magnitude of which would have made it appear impossible to any one not of the most determined purpose and with the softest of hearts. He discarded medical practice with the single purpose of rescuing the waifs and strays of the gutter, and he succeeded in turning thousands upon thousands of these outcasts into honest men and women and placing them in positions whereby they could gain their living and prove their gratitude to the noble founder of the homes in which they were dragged from misery and vice and taught the principles of Christianity. That many evinced this trait is shown by the grateful letters of emigrants received by him from all parts of our world-empire, and these must have solaced "Dr. Barnardo," as he was familiarly known, during his somewhat protracted illness which culminated last week. Millions of His Majesty's subjects may and will mourn the death of such a man, but millions also would give something to have lived the life he lived, and to have accomplished so noble a mission.

Medical News.

The Filling Up of Death Certificates.

THE Registrar-General for Ireland has issued a memorandum calling attention to the fact that it is highly desirable that medical practitioners should use, in their certificates of death, only those terms which are recognised by the Royal Colleges of Physicians of London and of Ireland. The list of diseases now used in the Registrar-General's Reports—a copy of which is printed on the third and fourth pages—is condensed from the nomenclature of the Royal College of Physicians, London, with the addition of certain unauthorised terms which are still constantly employed, but which are objectionable, either as being the names of symptoms merely, or as being otherwise indefinite. In the copy of the list enclosed with the memorandum these objectionable terms are printed in italics; and it is hoped that medical practitioners will assist the Office by abandoning, as far as practicable, their future use. The cause of death should be stated precisely and briefly; English names for diseases being used in preference to their equivalents in other languages. Vague terms such as *decline*, *consumption*, *tabes*, *cachexia*, &c., should be avoided; and *hæmorrhage* should not be assigned as the cause of death without indication of its origin and probable cause. *Dropsy* should never be returned as the cause of death without particulars as to its probable origin, *e.g.*, in disease of the heart, liver, kidneys, &c. In certifying deaths from small-pox the patient's condition with respect to vaccination should be carefully stated. The use of the term "Rubeola," as a synonym for measles should be discontinued. "Morbilli" is the only Latin equivalent for this disease recognised by the Royal College of Physicians. When diarrhœa is due to improper feeding, or to any kind of food infection, the fact should be mentioned in the certificate, and in certifying deaths from this cause, either the authorised term, "epidemic diarrhœa," or else its synonym, "infective enteritis," should invariably be employed. The term "*puerperal fever*" should no longer be used. Pyæmia, septicæmia, or septic intoxication, occurring as a complication of childbirth, should be described as puerperal pyæmia, puerperal septicæmia, or puerperal septic intoxication, respectively. Three separate forms of acute pneumonia have now been added to the list, viz., croupous or lobar pneumonia, broncho- or lobular pneumonia, and epidemic pneumonia; the old term for undefined cases of pneumonia being still retained. The term "*typhoid pneumonia*" should never be employed, as it may mean either enteric fever, with pulmonary complications, on the one hand, or pneumonia, with so-called typhoid symptoms, on the other. When "*phthisis*" is due to tubercle, the term "tuberculous phthisis" or "pulmonary tuberculosis" should be used instead of the ambiguous term *phthisis*, which is sometimes used to designate other than tuberculous diseases of the lungs. Deaths from hydrocephalus of tuberculous origin should be definitely assigned in the certificate to "tuberculous meningitis," so as to distinguish them from deaths caused by simple inflammation or other disease of the brain or its membranes. "Congenital hydrocephalus" should always be returned as such. Among cancerous affections, "carcinoma" is now distinguished in the list from "sarcoma." In all cases the organ or part affected by cancer should be specified. Disease of the spinal cord should always be distinguished from disease of the vertebræ. The classification of deaths from "paralysis" would be much facilitated if brain paralysis were always distinguished from paraplegia. In certifying deaths from brain paralysis, the terms "*hemiplegia*" and "*apoplexy*," which denote symptoms merely, might usefully be replaced by the names of such definite lesions as "cerebral hæmorrhage," &c. In certifying deaths from cerebro-spinal meningitis in its epidemic form, the term "cerebro-spinal fever" should be employed. It is hoped that the indefinite term "convulsions," will henceforth be restricted to those cases in which the true cause of that symptom cannot be ascertained. At present in Ireland, 14 per cent. of the total deaths of infants under one year old are referred to "*convulsions*." The use of both the terms "croup" and "membranous laryngitis" to designate non-diphtheritic affections of the larynx should be abandoned. *Membranous croup* should no longer be used as a synonym for laryngeal diphtheria. Wherever peritonitis occurs as an extension of morbid processes from other organs—the fact should be mentioned in the certificate. Whenever a tumour is known to be due to malignant disease, to tubercle, or to syphilis, the fact should be stated in the certificate. Whenever parturition or miscarriage has occurred within one month before the death of the patient, the fact should be certified, even though childbirth may not have contributed to the fatal issue. In every case of death by violence, or by suspected violence, the medical practitioner, in addition to stating the fact in his certificate, should advise the friends of the deceased to inform the Coroner forthwith. When the cause of death has been verified by a *post-mortem* examination, the latters "P.M." should be added. If medical men will but attend carefully to these directions, the work of classifying deaths will be much simplified, and statistics made of greater value.

The International Surgical Society.

THE first International Congress, which was held in Brussels during last week, has now closed, and is considered by those present to have been a distinct success. Over 200 delegates attended, representing the following countries:—Great Britain, France, Germany, Austria-Hungary, the United States, Belgium, Holland, Switzerland, Japan, Russia, Spain, Portugal, Sweden, Norway, Italy, Denmark, Greece, Finland, Roumania, Servia, and Egypt, all of whom received a cordial welcome from the Government and municipal authorities, various pleasure excursions and visits to monuments of interest being organised for the benefit of the visitors, and an exhibition of the latest surgical appliances in a suite of rooms adjoining the meeting-place of the congress. Several valuable and suggestive papers were read and discussed on the latest developments of surgical science, one of which we published in our last issue, and another by Professor Freidrich, of Griefswald, will be found in our columns this week.

St. Mary's Hospital Medical School, Paddington.

THIS school will open for the Winter Session on Monday next, when an introductory address will be delivered by Dr. Wilfred Harris, 3.30 p.m. On Tuesday, October 3rd, the annual dinner of past and present students will be held in the Whitehall Rooms of the Hotel Cecil, at 7 p.m.

Lady Doctor Fined.

AT Helston, Mrs. Mary J. Hall Williams, of Penzance, was recently charged, that, being a medical practitioner attending on Miss Margaret Williams, of Ivy Bank, Helston (since deceased), she failed to notify to the medical officer for the district that she was suffering from typhus fever. Defendant pleaded guilty, and stated that the symptoms were not clear enough to identify the disease until death actually occurred. She came to the conclusion that it was a case of typhus, and this she certified as the cause of death. She gave certain directions for disinfecting, but failed to notify the case to the medical officer of health. The Bench imposed a penalty of £1, with £1 12s. 6d. costs.

Scarlet Fever in Birmingham.

SINCE 1890, when compulsory notification of scarlet fever was first introduced in Birmingham, the number of cases have been as follows: 1890—2,995 cases, 209 deaths; 1891—1,468, 91; 1892—1,418, 68; 1893—1,614, 68; 1894—1,788, 75; 1895—2,964, 133; 1896—1,389, 154; 1897—1,929, 95; 1898—1,320, 47; 1899—1,255, 29; 1900—2,063, 93; 1901—3,314, 156; 1902—5,044, 293; 1903—2,855, 144; 1904—1,650, 144.

Apothecaries' Hall of Ireland.

SIR CHAS. CAMERON, M.D., D.P.H., has been elected Examiner in Hygiene; Professor W. N. Hartley, F.R.S., Examiner in Chemistry; and Mr. J. C. M'Walter, M.A.,M.D., D.P.H., Examiner in Pharmacy.

Jervis Street Hospital.—Appointment of House Surgeons.

IN consequence of Dr. W. B. Loughnan resigning his position as Senior House Surgeon in Jervis Street Hospital, the Governors have unanimously elected Dr. E. Purcell and Dr. J. M'Nelis house surgeons. Dr. Loughnan, previous to his leaving the institution, was the recipient of a handsome address and presentation from the resident staff of the hospital in recognition of the courteous manner in which he at all times discharged his duties among them.

University of Durham.

THE following candidates have passed the Second Examination for the degree of Bachelor in Medicine, during the present month:—Anatomy, Physiology, and Materia Medica (*Honours—Second Class*)—Charles Morris Saint, Henry G. Davison, Francis A. Robinson. *Pass List*—Kenneth B. Allan, Charles M. Brown, Isaiah Hodgkinson, Edward P. L. Hughes, Hedvig C. Kellgren, Frank W. Melvin, Charles J. Neilan, Friederike Rahtkens, Basil Taylor, Eric F. Waddington.

Notices to Correspondents, &c.

☛ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," Old Subscriber," &c. Much confusion will be spared by attention to this rule.

THE FREEDOM OF THE SOCIETY OF APOTHECARIES.

Licentiates of the Society of Apothecaries, London, are notified in our advertisement columns, that the Court propose to admit this year ten Licentiates to the Freedom which confers certain privileges as London citizens. Applicants must forward certificates as to their professional standing, signed by at least two medical men. The fee for admission, including stamp is £28.

DR. MUSCAT (Paris).—The matter is under consideration. You will receive a private note in a day or two.

NURSING THE INSANE.—An examination for the Certificate of Nursing and Attending the Insane will be held by the Medico-Psychological Association on Monday, November 6th. Candidates should write to Dr. Miller, Hatton Asylum, Warwick, for a schedule.

DR. B. W. L. (Edinburgh).—After careful reading we have decided adversely.

J. WILLIAMSON (Manchester).—The relative populations of the cities referred to, as per official statistics, are: London, 4,684,794; New York. 3,948,191; Paris, 2,660,559; Berlin, 2,021,254; Vienna, 1,877,839; St. Petersburg, 1,248,122.

S. E. R.—According to the natural sequence, yes.

DR. L. F. S. will receive a private note as soon as we have made the necessary inquiry.

PROFESSOR.—Dr. Pinard's talks with young girls on the rearing of infants are embodied in a little volume entitled: "La Puériculture" (Armand Colin, Paris. Price 1 fr. 50. It is well illustrated.

Appointments.

HENRY, E., F.R.C.S. Eng., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Long Sutton District of the County of Lincoln.

MACVIE, S., M.B., M.S.Ed, Certifying Surgeon under the Factory and Workshop Act for the Chirnside District of the County of Berwick.

McWALTER, J. C., D.P.H., F.F.P.S.Glasg., M.D.Brux., Examiner in Pharmacy to the Apothecaries' Hall of Ireland.

MUIR, WM., M.B., C.M.Glasg., Medical Officer to the Post Office in Davidsons Mains District, Midlothian.

O'MEEHAN, P, L.D.S.R.S.C.I., Honorary Consulting Dental Surgeon, St. John's Hospital, Limerick.

PERN, E. C., M.R.C.S, L.R.C.P.Lond., Medical Officer of Health for the Droxford Urban District Council. Hants.

RABY, LEONARD, M.D.Durh., Medical Officer for the Second District by the Devizes Board of Guardians.

ROANTREE, J., M.B., B.S., R.U.I., Certifying Surgeon under the Factory and Workshop Act for the Newbridge District of the County of Kildare.

ROUTLEY, E. W., M.R.C.S.. L.R.C.P, Lond., Certifying Surgeon under the Factory and Workshop Act for the Aldershot District of the County of Hants.

Vacancies.

Farringdon General Dispensary, Bartlett's Buildings, Holborn, London, E.C.—Resident Medical Officer. Salary £120 per annum, with apartments, coals, gas, and attendance. Address, the Honorary Secretary.

Grove Hall Asylum, Bow, London, E.—Assistant Medical Officer, Salary at rate of £150, with board, apartments, attendance, and washing.

Hartshill, Stoke-upon-Trent, North Staffordshire Infirmary and Eye Hospital. Senior)House Surgeon. Salary £100 per annum, with apartments, board, and washing.

Kidderminster Infirmary and Children's Hospital.- House Surgeon. Salary £120 per annum, increasing to £150, with rooms and attendance. Apply to the Secretary.

Lancashire County Asylum, Winwick, Warrington.—Assistant Medical Officer, unmarried. Salary £150 per annum, increasing to £350, with apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Leeds General Infirmary, Leeds.—Laboratory Curator. Salary £150 per annum. Full particulars of the General Manager.

Leicester Corporation of Isolation Hospital.—Resident Medical Officer for the Borough Isolation Hospital. Salary £120 a year, with board and residence. Applications to Dr. Millard.

City of Liverpool.—Fazakerley Hospital for Infectious Diseases.—Medical Superintendent. Salary £400 per annum, increasing to £600, with house, coal. and lighting. Further particulars of the Town Clerk, Liverpool.

Manchester Royal Infirmary.—Resident Surgical Officer, unmarried. Salary £150 per annum, with board and residence. Further particulars on application to W. L. Saunder, Esq,

Rainhill, near Liverpool, County Asylum.—Assistant Medical Officer unmarried. Salary £150 per annum, increasing to £850, with apartments. board, and washing. Applications to the Medical Superintendent.

Salisbury General Infirmary.—House Surgeon. Salary £100 per annum, with apartments, board, and lodging. Also Assistant House Surgeon. Salary £50 per annum, with apartments, board, and lodging. Immediate application to the Secretary.

Wakefield. West Riding Asylum.—Assistant Medical Officer. Salary £140, rising to £160, with board, lodging, washing, &c. Application to the Medical Director.

Wolverhampton and Staffordshire General Hospital.—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the House Governor.

Waterford County and City Infirmary.—House Surgeon. Salary £100 per annum, with board, &c. Applications to the Secretary. (See Advt.)

Births.

BALFOUR.—On September 19th, at Court Lodge, Deal, the wife of Andrew Balfour, M.D., of Khartoum, of a son.

HUNNARD.—On September 19th, at The Elms Mansfield, the wife of Arthur Hunnard, M.B., of a daughter.

SYLVESTER.—On September 19th, at St. Petroc, Leiston, Suffolk, the wife of Herbert Mayris Sylvester, M.R.C.S., L.R.C.P., of a son.

WARING.—On September 22nd, at Fort Rowner, Gosport, to the wife of Captain A. B. Waring, R.A.M.C., a son.

Marriages.

ARMSTRONG—CLARKE.—On September 20th, at Christ Church. Lancaster Gate, London. W., William Anderson Armstrong, elder son of Joseph F. Armstrong, M.D., J.P., of South Shields, to Helen Marianne, younger daughter of Charles T. Clarke, of Okehampton, North Devon.

EVANS—POLLOK.—On September 13th, at St. George's Church, Edgbaston, Thomas David Fabian Evans, M.B.Edin., M.R.C.S Eng., younger son of the late Fabian Evans, M.D., Cantab, F.R.C.P Lond., to Selina Elizabeth, danghter of the late Morris Pollok, of Govan, N.B.

Deaths.

BATTYE—At 84, Belgrave Road, London, S.W., on September 20th, John Howard Battye, M.D., younger son of the late Dr. R. Fawcett Battye, of 123, St. George's Road, S.W., aged 52.

DARLEY.—On September 19th, at Blackrock, co. Dublin, Richard L. Darley, son of the late Henry Darley, M.D.. of Dublin.

HUNTER-STEWART.—On September 22nd, at Edinburgh, after a brief illness, Anne. wife of Chas. Hunter-Stewart, M.B., Professor of Hygiene, University of Edinburgh.

MACAN.—On September 20th, at Nordrach, Black Forest. Germany, John Wanklyn Macan, B.A.I. Univ. Dublin, eldest son of Sir Arthur Macan, M.B., F.R.C.P.I., aged 27 years.

MORETON.—On September 20th at Earlscroft, Kelsall, Cheshire, Janet Steel, wife of James Earl Moreton, F.R.C.S., aged 75 years.

UNDERWOOD.—On September 17th, at 10, College Road, Saltley, Phyllis Maude, wife of A. C. Underwood, M.R.C.S., aged 19 years. Also on September 6th, the baby son of the above, aged 16 days.

WALKER.—On September 23rd, at Earlsmead Clacton-on-Sea, in her 86th year, Frances Ann, wife of Surgeon-General James Pattison Walker, M.D.

OPERATIONS—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopædic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Gt Ormond Street, (9.30 a.m.), Gt. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynæcological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's 1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopædic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St. George's (1 p.m), St. Mary's (1 p.m.) Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.35 p.m.), Middlesex (1.30 p.m), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynæcological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopædic (2 p.m.), City Orthopædic (4 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, OCTOBER 4, 1905. No. 14.

Original Communications.

CYTODIAGNOSIS. (a)

By J. ODERY SYMES, M.D., D.P.H., &c.,
Assistant Physician and Bacteriologist, Bristol General Hospital.

MUCH attention has recently been drawn to the determination of the nature and variety of the cellular elements which are to be found in pathological body-fluids, and to this method of investigation the term cytodiagnosis, or cytology, has been applied. It has been claimed that from a knowledge of the cells present, it is possible not only to determine the nature of the morbid process, but also to forecast in some degree the subsequent progress of the disease. It is not my purpose to deal with results which have been recorded by others, but to give as briefly as possible my own experience of this method of examination.

The fluid to be examined is obtained either by means of an exploring syringe or is drawn off into the bottle of an aspirator. If a clot form this is broken up by adding to the fluid a number of large glass beads and then shaking the vessel for a few minutes. A quantity of the fluid is then centrifugalised until a visible sediment forms; the sediment is spread thinly over glass slides which are placed in a hot cupboard to dry. The films so prepared are then stained with Jenner's or Leishmann's stain, or they may be fixed by placing in equal parts of alcohol and ether, and then stained with some combination of eosin, methylene blue, and hæmatoxylin. After washing in distilled water, the films are again placed in the incubators to dry. They must not be dried by pressing between blotting-paper as the cells are apt to be brushed off the slide. A differential count may be made with a 1-6th inch objective, but personally I prefer to use a 1-12th inch. There is sometimes considerable difficulty in distinguishing between the various cells; for instance, it may be difficult to decide whether a cell is a lymphocyte or an endothelial cell, and in old-standing effusions the imperfect staining, vacuolation, and disintegration of the cell substance may render it impossible to classify some cells. This difficulty is seldom a serious one, and I have generally found that counts made from the same films by different observers very closely approximate to one another.

Pleural Effusions.—Cytodiagnosis promises to be of the greatest service in the differentiation of the various forms of pleuritic effusions. In determining whether such effusions be of mechanical or tuberculous or pyogenic origin, our laboratory methods are both tedious and imperfect. Whilst direct examination of stained films of the fluid may occasionally reveal micro-organisms, more commonly it is fruitless; cultures have in my experience generally given negative results, and in the case of the tubercle bacillus are seldom attempted; inoculation involves a long delay, and the result may be vitiated by the fact that the bacilli injected were dead, or the guinea-pig may die from toxins contained in the fluid. In cytodiagnosis, however, we have a method which is capable of being performed practically at once, and at the bedside.

Stated briefly, the distinctions between the various forms of pleural effusion as revealed by cytodiagnosis are as follows:—In tuberculous effusions the lymphocytes predominate; in effusions due to other micro-organisms there is a high percentage of polymorphonuclear leucocytes; in mechanical transudations large numbers of endothelial cells are found; and in cancer of the pleura certain cells characteristic of the new growth are to be detected.

The following figures will be found to substantiate this statement:—

Tuberculous pleurisy, five cases. Average of eight counts. Lymphocytes, 94 per cent. Polymorph. leucocy., 3 per cent. Endothel. cells, 3 per cent.

Infective pleurisy, six cases. Average of nine counts. Lymphocytes, 41 per cent. Polymorph. leucocy., 50 per cent. Endothel., 9 per cent.

Mechanical pleural transude, one case. Average of two counts. Lymphocytes, 89·6 per cent. Endothel., 10·4 per cent.

Cancer of pleura, one case. Lymphocytes, 64·6 per cent. Polymorph. leuco., 23·3 per cent. Endothel., 12·1 per cent.

Tuberculous pleurisy.—All the cases examined were free from tubercle in the lungs and other organs—primary tuberculous pleuritis. In one case, the diagnosis was assured by the discovery of tubercle bacilli in the fluid; two cases reacted typically to tuberculin; and in the remaining two I have had to rely upon the clinical diagnosis of the medical attendant.

The average specific gravity of the fluids was 1017, the highest 1023, the lowest, 1015. All the specimens coagulated spontaneously. These two features, a moderately high specific gravity and a marked tendency to clotting, help to distinguish tuberculous effusions from mechanical transudations. There is yet one further distinction, namely, that in a tuberculous pleural fluid one finds a constant though small percentage of polymorphonuclear leucocytes varying in my own cases from 1 per cent. to 5 per cent. The more recent the tuberculous fluid, the more numerous the polymorphonuclears. In very old effusions or after repeated tappings they may be very scarce.

(a) Read at the Meeting of the Med. Chir. Society on March 8th, 1905.

The lymphocytes in tuberculous pleurisy are mostly of the small variety (6 to 1), and their nucleus nearly fills the cell. The large lymphocytes are often pale, degenerated, and vacuolated.

A case, which was probably tuberculous, but which I have not included in the list, was one which followed an operation in which the wound suppurated. The effusion cleared up after a single aspiration. There were 25 per cent. of large, 74 per cent. of small lymphocytes, and 1 per cent. of polymorphonuclears.

In pleural effusions, secondary to pulmonary tuberculosis, the cell count is entirely different, the majority of the cells present being in such cases of the polymorphonuclear variety, and many of these being coarsely granular.

Infective pleurisy.—Of the six pleuritic effusions of infective origin, one followed an attack of scarlet fever; three followed lobar pneumonia; and two occurred with acute rheumatism complicated by pericarditis. The average specific gravity of the fluid was 1018. With one exception (a pneumonia) the fluids coagulated spontaneously.

The characteristic feature of such effusions is the high percentage of polymorphonuclears. This percentage varied in these cases from 14·4 per cent. to 93 per cent. of all the cells present. In none of the cases did the fluid become purulent. It is stated that if the leucocytes exceed 90 per cent. of the total cells, and if their nuclei be seen to divide up into balls (pyenosis), suppuration will occur. Pyenosis I found in nearly all the specimens, but the highest count excluding the rheumatic cases was 53·5 per cent. of polymorphonuclears in a pleurisy following pneumonia.

It is so seldom that one obtains fluid in rheumatic pleurisy that I may be permitted to give the following details of the two counts I have made.

Spec. 1.—Cloudy. Sp.g. 1018, alk. Spontaneously coagulates. Lymphocytes, 68·4 per cent. Endothelial cells, 17·25. Polymorphonuclears, 14·4 per cent.

Spec. 2.—Cloudy. Spontaneously coagulates. Lymphocytes, 5 per cent. Endothelial cells, 2 per cent. Polymorphonuclears, 93 per cent.

This marked difference in the counts of two rheumatic pleural effusions has been noted by other observers. The explanation is not clear, but possibly the first specimen in part partook of the nature of a mechanical transudation secondary to the failure of the heart from peri-, myo-, and endocarditis. In neither cases could the diplococcus rheumaticus be isolated from the fluid.

In the pleurisy following scarlet fever and in those following pneumonia, many large leucocytes were seen, probably of a phagocytic nature. As the fluid becomes absorbed the leucocytes decrease and the lymphocytes increase.

Mechanical pleural transudations.—The specimens which I examined were taken from a case of chronic nephritis with general anasarca. The specific gravity was 1010, and the fluid did not coagulate. There were present 89·6 per cent. of lymphocytes and 10·4 per cent. of endothelial cells. The endothelial cells occur in plaques or singly, and were markedly vacuolated and degenerated, in some cases showing little else but the nucleus. Twin cells joined by a bridge of ground substance, the whole looking like a dumb-bell, are very common in these effusions. There are, too, more than the usual number of red blood corpuscles and these show granular changes.

Pleurisy due to secondary deposits of new growths.—I have already referred to the cytology of the only case which came under my observation. As the cells present differed in no way from those found in cancerous ascites, I shall describe them under that heading.

Ascitic Fluid.—Ten specimens of ascitic fluid were examined. Of these four were secondary to cirrhosis of the liver, one was secondary to cardiac failure, two complicated chronic Bright's disease, and three were of malignant origin.

The mechanical transudations show lymphocytes and endothelial cells only. The four specimens obtained from cases of cirrhosis of the liver had an average specific gravity of 1013, lymphocytes 93 per cent., endothelial cells 7 per cent. The cardiac ascites was almost identical with this, showing lymphocytes 93·5 per cent., endothelial cells, 6·5 per cent. Both showed many red corpuscles, and a very few polymorphonuclears.

The fluids obtained from the two cases of nephritis cannot be regarded as typical, as in both cases suppuration followed, perhaps as the result of one of the repeated tappings. Both specimens contained in addition to lymphocytes and endothelial cells a high percentage of polymorphonuclears.

There is one noticeable characteristic of films made from ascitic fluids, namely, the frequent presence of bacilli singly or in groups. From observations I have made I am inclined to think that such are not due to accidental contamination, but are present in the fluid in the abdomen.

Of three specimens of fluid from malignant disease of the peritoneum, one was obtained at the time of operation from what proved to be a case of malignant disease of the pylorus and neighbouring structures. In the other two cases I am able, from an examination of films, to make a diagnosis of malignant disease before operation was undertaken. One proved to be a case of diffuse malignant papilloma, and in the other the nature of the growth is still uncertain. The specific gravity of these malignant fluids varied between 1011 and 1024, the average being 1018. There was always a large admixture of red blood cells and in none of the cases did the fluid coagulate.

The differential counts were as follows:—

1. Carcinoma of pylorus and peritoneum.—Sp.g. 1024. Lymphocytes, 60 per cent. Endothel. and epithel., 35·8 per cent. Polymorphonuclears, 4·9 per cent.

2. Malignant papilloma of peritoneum.—Sp.g. 1021·6. Lymphocytes, 80 per cent. Endo- and epithel., 19 per cent. Polymorphonuclears, 1 per cent.

3. ? Malignant.—Sp.g. 1011. Lymphocytes, 62; endo- or epithel., 36 per cent. Basophils, 4 per cent.

Whilst it was not possible to detect in any of these specimens a typical cancer cell, if there be such a thing, yet there were several cells which are not found in either infective or mechanical exudations. The following are, in my opinion, suggestive of a malignant origin:—(1) Plaques of endothelial cells. (2) Very large cells of epithelial type containing many nuclei. (3) Cells larger than endothelial cells and containing granules and vacuoles, and having large oval nuclei with many large granules or nucleoli. (4) Small multinucleated cells showing rapid splitting up of the nucleus (mitosis).

The Urinary Tract.—During the past few years I have had a very large number of specimens of urine sent to me for cytodiagnosis. The usual request is for a differential diagnosis between calculus of the kidney, new growth, pyelitis, and cystitis. The deposit is best examined in the fresh state, and it is often possible to recognise the transitional epithelium of the pelvis of the kidney, spindle or pear-shaped cells, or rounded cells with well-marked nuclei and long tail-like processes. The presence of large numbers of such cells together with blood, leucocytes, and hyaline casts is suggestive of stone in the kidney, whilst if there be pus and still larger casts a diagnosis of pyelitis is justifiable. Larger transitional epithelial cells are found in inflammation of the bladder, and are readily recognised if there be not too much pus. Large masses of epithelial cells and fragments of growth in the urine would confirm a suspicion of malignant disease, but I have only once been able to find such. Now that the cystoscope, the urinary separator, and X-rays are available, the value of an examination of the cells in urine is of comparatively small value.

Hydrocele Fluid.—The fluid from eight cases of hydrocele was examined. These were idiopathic or essential hydroceles of many years' standing, in which trauma, tubercle, syphilis, new growth, and cysts of the cord could be excluded. In one case the fluid contained a visible trace of blood, but in all the others it was free from any milkiness or opacity. The average sp.g. of the fluid was 1019·5; the highest being 1022 and the lowest 1016. There are very few cells to be found in hydrocele fluid, and these consist of endothelial cells and lymphocytes. In the cases in which it was possible to make a differential count there were found endothelial cells 93 per cent., lymphocytes, 7 per cent. In six out of the eight cases, large numbers of spermatozoa were found. Some of the spermatozoa preserve their perfect shape, others are shrivelled or degenerated, and yet others appear to lie in the endothelial cells. Barjon and Cade have suggested that the presence of spermatozoa is due to the rupture of small cysts, especially cysts of the epididymis into the vaginal cavity, and they regard this rupture as the sole cause of essential or idiopathic hydroceles. Of the two cases in which spermatozoa were not present, one was that of a paralysed man, æt. 76; and one a young man who had recently had pure carbolic acid injected into the sac with a view to effecting a cure. In this case the fluid was obtained at a time when the sac was being excised, and it was mixed with so much blood that even had spermatozoa been present it is highly improbable they would have been detected. The objection that may be raised that the presence of spermatozoa may be due to an accidental injury to a seminal tube at the time of puncture is met by the fact that in one successful case the sac had been carefully incised for the purpose of excision. The spermatozoa will only be found if the fluid be efficiently centrifugalised.

Cerebro-spinal Fluid.—I have examined six specimens of cerebro-spinal fluid drawn off by lumbar puncture. Four of these were apparently normal fluids, clear, free from albumen, sp.g. 1002, containing very few cells, and no bacteria. However carefully such a fluid be centrifugalised, not more than two or three cells will be found, and these are either endothelial cells or lymphocytes much degenerated. Red blood cells are, however, constantly present. The remaining two specimens were slightly turbid, one showing a small clot; both of these contained polymorphonuclear leucocytes. They were from suspected cases of meningitis, one presumably being a case of epidemic cerebro-spinal meningitis.

Stated briefly, it has been found by cytodiagnosis that the presence of appreciable numbers of polymorphonuclears in the cerebro-spinal fluid is an indication of acute meningitis from such organisms as the pneumococcus, streptococcus, or diplococcus. In fatal cases these are present, but in cases progressing towards recovery they are gradually replaced by lymphocytes intra-cellularis. A lymphocytosis is found in tuberculous meningitis, tabes dorsalis, general paralysis of the insane, zona, anterior poliomyelitis, and early syphilitic disease of the nervous system. In hysteria, cerebral tumour, not involving the cortex, peripheral neuritis, and alcoholism, the cerebo-spinal fluid is normal.

General.—The fluid obtained by tapping the abdominal wall or the limbs in cases of anasarca contains too few cells to permit of a differential count, and these are principally lymphocytes. The average specific gravity of such fluid was in my own cases 1020.

Cancer cells in sputum or in gastric contents I have never been able to find, and a cytological count of these materials is useless.

From the foregoing it will be seen that cytodiagnosis is a useful addition to our present methods of clinical diagnosis. Its results are not infallible and are sometimes misleading. To secure the most trustworthy report on a morbid fluid we must combine with cytodiagnosis our other methods of examination.

We must examine its appearance, its specific gravity, its coagulability, its chemical composition, spectroscopic characters, its bacteriological content, and hæmolytic and agglutinating properties.

THE IRISH MEDICAL ASSOCIATION: ITS RE-ORGANISATION AND ITS FUTURE. (*a*)

By RICHARD R. LEEPER,

Ex Hon. Sec. and Sec. to Council I.M.A.

III.

To those who have been interested workers and anxious followers of the fortunes of the Irish Medical Association in past years the present time is one of great expectations and hopefulness. Men worked in years past oppressed by the dispiriting sense of vagueness and the indifference of those whose interests were vitally involved in the work of the Association, and one was ever conscious of a sense of failure to do much in the great work of endeavour to redress the grievances which overshadowed the lives and hindered the

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(*a*) Being the third of a series of articles specially communicated to the columns of the Medical Press and Circular by prominent members of the Irish Medical Association.

work and usefulness of the Poor-law medical officers.

This present time is surely one of promise, and speaks to us of great possibilities. With the nativity of the country branches and all the good work of the past six years, the Association now finds itself in a position to re-organise upon a broader and more workmanlike foundation, and is approaching this epoch in its history with a widespread interest amongst its members that such should be entirely successful and mark another era of greater work and usefulness to the profession. The highest ideal of life and fitness in a man has always been associated with the possession of a sound mind in a sound body, and if we place this ideal of individual health before the Association of the future and regard it as an individual seeking to attain it, the most we can desire for its future is the possession of one sound and respected and representative governing mind built up from and sustained by the stimuli of a sound and active body of members, each of whom will be prepared at all times to perform his individual duty to his fellows, and work for the good of the *cosmos* as a whole and his own personal necessities as a secondary consideration.

One regarded with satisfaction the appointments by the Council of the Re-organisation Committee, especially as its members were chosen from all parts of the country, and who ought therefore to be best able to know of the wishes and requirements of the bulk of the members. It was with regret, however, that one received their report; unfortunately it was not unanimous, and showed that wide differences of opinions existed between members of the committee, and their report lost thereby much of its power and utility as a guide to the members anxious and urgent for the reconstruction of our time-worn organisation. The great and sole object to be secured by this re-organisation is the acquisition for the Association of a working and constitutional executive in whom the members who must create it will have fast faith. The members must send forward only such as they carefully select and have full confidence in, and the selected representatives must be in thorough sympathy and accord with their constituents.

I would recall to the minds of this undecided differing committee of re-organisation the fable of Æsop, of the "Belly and the Members." Once upon a time the members refused to work for the belly, who led an idle life, and thought better of their requirements; then the belly wasted, and the members also wasted in due time, and the end was the inevitable destruction of both!

The work of the members must be for the entire future medical state showing itself by increased *esprit de corps* and an absence of all rancour and captious criticism.

The point, I take it, to be decided by the October meeting is how best to secure a thoroughly representative government of a workable number of members. It is not so much, to my mind, whether branch representatives shall be chosen or otherwise, but the main question at issue is the acquisition of an executive possessing the confidence of all, and how best this is to be secured is merely a matter of detail to be decided by the opinion of the majority of those present, whose decision should be peremptory and final, at once and for ever clearing the way for the active work of reconstruction and progress.

One of the greatest executive difficulties which the committee of Council has always experienced has been the necessity to at times take prompt and decided action without the necessary time being available for consultation and conference with the Council and bulk of the members. A clear policy may be enunciated at the annual conference or at the Council, but much may occur within a very short period, and sudden situations have arisen, and are now more likely to arise even than formerly, when real interest is taken in Poor-law reform. The difficulty of securing prompt attendance of representatives at frequent meetings voicing the feelings of the community must be met, and no scheme for re-organisation will be of much value which does not primarily secure it.

It occurs to me that much might be done by representatives or branch secretaries sending to the members of their respective constituencies observation blank forms, whereon each member could and ought at stated periods to send forth his views upon current topics of interest and his opinions and suggestions upon all matters of interest to the Association.

I have already, in the *Journal* of the Association, called attention to the want and failure on the part of members to report promptly all failures in the working of the present system of Poor-law medical relief, so that the existing defects of the system could be brought forward promptly as an ever-present fighting policy for the Association, with instance and time, and place, and effects of such failures in the existing system upon the sick poor. This would strengthen agitation and remove from it the stigma by which it was, and is branded as a mere effort to increase the salaries and emoluments of doctors wholly selfish and without public interest. It is an undoubted fact that the Poor-law medical service to-day is in a better case than ever it was before.

Old dispensary doctors, time-worn in the service, have told me so, and although the question of superannuation and many other matters still call for redress, yet there is surely no need to be disheartened or to regard the future of the Association and its existing efforts in Poor-law reform with apprehension or despondency. A re-organised Association, worked on sound and constitutional lines, must and will in future enormously advance the interests of our profession, and add to the dignity, utility and emoluments of the men practising in Ireland, and chiefly in rural Ireland.

One other thought occurs to me in connection with the newly-raised *questio vexata* of representation. We all know of such branches of the Irish Medical Association as are to be found at Mayo, Inniskillen, Wexford, Cork, and Belfast. In these localities medical personalities who are capable and willing workers occur to my mind as suitable representatives at once—men whose selection would admit of no criticism; but elsewhere, and in those parts of our country where the Association's work has lain fallow, and where no decided steps in advancement have been taken, these are the places where energy has to be sought out and encouraged, and if the work of re-organisation is to be effective, this work must be promptly undertaken.

The old saw of the chain and its strength being proportionate to its weakest link occurs to me. Let those responsible for the re-organisation think of this and work hard to strengthen these weakest links.

In these times of the passing away of old things, I wish to impress upon the Association the need for grave and calm deliberation upon the proposed appointment of a whole-time paid secretary. I believe such an official should be appointed, but I would recommend the newly-appointed executive or governing body, or whatever else it may be called, to select a person with a legal training and to trust little to his unaided and untrained judgment for the first term of his office.

French Clinical Lectures.

HOW TO DEAL WITH A
FOREIGN BODY IN THE ŒSOPHAGUS OF THE CHILD.

By L. BERARD, M.D.,
Surgeon to the Lyons Hospital;
and R. LERICHE,
House Surgeon.

[SPECIALLY TRANSLATED FOR THIS JOURNAL.]

In the case of a child who has swallowed a foreign body, two questions at once suggest themselves, viz., where is it impacted and what has to be done? In spite of the frequency of this accident there remains a curious divergence of opinion as to the proper course to pursue, in fact, although the literature of the subject is extremely voluminous, it is impossible to deduce therefrom any rule of conduct which can be adopted without hesitation.

In the course of the last two years we have had to deal with some twelve cases of the kind, in nine of which we had to intervene. Of these nine, in one, extraction of the foreign body by the mouth was effected without much difficulty, but in the other eight we had to do external œsophagotomy to obtain possession of impacted coins. It may therefore not be without interest to give the results of our experience in the hope that they may enable practitioners to intervene in this class of cases, if not always with success at any rate with a minimum of risk.

The behaviour of the œsophageal walls towards foreign bodies has been greatly misapprehended, for as a rule they are far from displaying the remarkable tolerance that we have been asked to believe, indeed, the rule of conduct for the surgeon, says Terrier, is that it should be the same as in hernia, "imitating the attitude of the surgeon who, called to a case of hernia, never leaves his patient until he has reduced or operated upon the hernia, so the practitioner, in presence of the impaction of a foreign body in the œsophagus, should not leave his patient until it has been got rid of."

Up to the age of seven or eight years, the œsophagus is a mere slit, the opposite walls being in contact, and it admits of dilatation to from 15 to 30 millimetres. It follows that any foreign body of greater dimensions is likely to become impacted, and if of irregular outline or if there be spasm, even smaller bodies may be arrested. In 95 per cent. of the cases the impaction takes place above the second anatomical narrowing, *i.e.*, just behind the manubrium, on a level with the cross formed on the skiagram by the shadow of the two clavicles and the vertebral column. Less frequently it is situated behind the cricoid cartilage. Such bodies are only met with in the thoracic œsophagus after ineffectual attempts to push them onwards.

Nine times out of ten the coin, for it is usually a coin, becomes impacted vertically and crossways. A passage is left in front or behind, through which food passes with more or less difficulty, and its edges tend to stretch the walls eccentrically. If it be not promptly extracted, the pressure exerted by its edges on the walls, rapidly determines ulceration, and ultimately perforation. With a pointed object perforation is apt to be very rapid. The mucosa, thinned and ulcerated, soon becomes infected, and the inflammation, extending by contiguity runs one of two courses.

Sometimes the inflammation is peculiarly virulent, either because the object is itself septic or because it is undergoing decomposition, in which event we get a gangrenous abscess running a rapid course which soon causes death unless relieved. Operating on the day after the accident Lieblein found the mucous membrane perforated, the walls infiltrated, and of a greyish-green colour, and death took place soon after. Hofmeister relates the case of peri-œsophageal abscess opened by him on the fourth day for the extraction of a bone which lay free in a collection of pus outside the œsophagus, and Felizet that of a child who succumbed to mediastinal abscess ten days after swallowing a halfpenny.

Usually, especially if the body be rounded, the process is less acute. Six, eight, or ten days after the accident we find peri-œsophagitis of variable severity leading to the formation of adhesions with neighbouring structures. The recurrent laryngeal nerve may be involved, leading to laryngeal spasm and respiratory troubles which supervene on the second or third day. These complications all contra-indicate extraction by the mouth, and add to the difficulty of surgical intervention later.

Perforation of the œsophagus may give rise sooner or later to encysted abscess or may allow of the passage of the foreign body into a neighbouring organ. This accounts for the strange migrations of such foreign bodies, the recurrent neuritis, the vascular, tracheal, and bronchial perforations that constitute the four principal complications of stasis of a foreign body in the upper part of the digestive tract.

The first of these is the rarest. Involved in the inflammatory process, the recurrent laryngeal nerve usually gives rise to merely fugitive disturbances in respect of the vocal cords though these are occasionally of a permanent character. Clinically, the muscular paresis thus induced is manifested by laryngeal dyspnœa and hoarseness.

Vascular perforations are more frequent. The ulceration may extend to any of the neighbouring vessels, thus we have seen death result from perforation of the aorta. Terrillon relates the case of a lad who, sixteen days after swallowing a halfpenny, died in half an hour after an attack of hæmatemesis; and Egloff a case in which a denture was extracted by œsophagotomy, but the patient died six days later from hæmatemesis due to ulceration of the inferior thyroid artery.

The symptoms in tracheo-œsophageal or broncho-fistula is less dramatic. Eleven cases of the kind were collected by Malkhasian, who showed that, if less fatal, it is nevertheless an extremely grave complication. It gives rise to violent attacks of dyspnœa with violent cough and difficulty of breathing whenever the patient attempts to swallow liquids. Sometimes the perforation is visible with the laryngoscope and it is almost always so by the aid of the œsophagoscope. Delayed extraction of the foreign body does not afford immunity against this accident which may supervene long after removal when everything appears to be going on satisfactorily.

We need not insist upon laryngeal compression and œdema of the glottis, which appear to be very rare, but there is one symptom that often follows this mishap in children, viz., rapid cachexia. The accident may have been forgotten, the child may seem to swallow without difficulty when sooner or later the health begins to fail, the child becomes depressed and irritable, and loses flesh, its complexion assuming the pale, wan appearance associated with acute intoxication. We have noted this on the fourth day, but the most instructive case of the kind is that recorded by Abbé. A patient was admitted with dysphagia and emaciation, and was thought to be in the last stage of phthisis. Exploration demonstrated the presence in the œsophagus of a foreign body, and the patient then remembered having lost a denture a year previously.

Of course this is not always the case, for there are numerous instances on record of foreign bodies that have remained fixed for many years, but such cases, it must be remembered, are altogether exceptional. Even after the lapse of many years the foreign body usually finishes by causing ulceration, accompanied by intense peri-œsophagitis. For this reason, after the third or fourth day, even with rounded objects, any attempt to remove it blindly by the mouth by the aid of our present instruments is in our opinion attended by considerable risk.

For the same reason we would deprecate exploration of the œsophagus by bougies and probangs whenever the diagnosis can be arrived at in any other way. Certain it is that the passage of a sound, and more particularly of a probang, is often dangerous and frequently useless. Even comparatively large bodies may escape the grasp of the instrument; in short, the method is one which ought to be left to practitioners living in remote parts of the country where skiagraphy is not available. In any case the instrument should be introduced with great gentleness, and as soon as the site of the object has been determined no further attempt at introduction should be made. The only safe and sure means of making the diagnosis is by skiagraphy, and by the aid of the œsophagoscope. We omit any reference to the palpation of the neck, since this but rarely gives information of value.

Radioscopy ought always to be employed whenever available, but the observation should be made immediately before the operation for the removal of the object for it is disagreeable to perform œsophagotomy for a coin that has since found its way into the stomach, as happened to M. Sebileau.

Œsophagoscopy, curiously enough, is little employed in France, though it is in general use in Germany and Switzerland since Mikulicz's researches. In only one of our cases was it employed, that of a child sent to us by Dr. Garel for operation. It can only be employed under an anæsthetic and it is only when one is prepared to proceed to the extraction of the body *per via naturales* that one would be tempted to have recourse to this procedure. It is doubtless the safest and surest method, but one cannot expect every practitioner to be *au courant* with its manipulation, and moreover one may not have the instrument at hand. Since the instrument is delicate and expensive and requires the administration of an anæsthetic, its use is likely for some time yet to remain in the hands of laryngologists.

Having established the nature and exact situation of the body, the next question is as to the means to be employed for its extraction. We have the choice of three plans; we may try to remove it by the mouth, or by œsophagotomy, or we may push it into the stomach. We shall have little to say with regard to the last-named. It is not indicated when the body is situated in the cervical œsophagus, and it should only be employed in presence of soft, digestible masses not of their nature dangerous, and for bodies impacted in the cardia. For solid objects the pushing method is working in the dark, it may force the angles of the foreign body into the mucosa and fix it more firmly than ever or merely push it out of reach of operative procedures; moreover, in a friable or inflamed œsophagus we are not unlikely to lacerate the walls. The plan of endeavouring to secure ejection by the administration of emetics or provoking emesis by other means, is illogical, often causing dangerous spasm and fixing the body more firmly than before. Comparatively small objects may sometimes be dislodged by giving pultaceous food, especially if the attempt be made soon after the accident, but if within twenty-four or forty-eight hours at most we have not been successful it is preferable to proceed at once to operation.

There are plenty of instruments to assist us in extraction by the mouth, notably Fergusson's umbrella, in current use in England, Kirmisson's hook, and Graefe's basket. Many patterns of forceps are employed, but the great objection to their use is that, working in the dark, they are liable to seize the mucous membrane instead of the object. As far as possible they should only be made use of under control of the finger. In Germany removal is often effected by the aid of, and through, the œsophagoscope, and, Von Hacker's results have been brilliant enough to command serious consideration. This method has the advantage of enabling us to grasp the object in sight, but for the time being, the procedure is not likely to come into general use for the reasons mentioned above. Even in skilled hands the plan is only to be recommended in recent cases, and when, on inspection, we have made sure that the œsophageal walls are in good condition.

There remains extraction by Graefe's basket and instruments of the same kind. Instruments of this class are the best known, and the easiest to handle, but they are also the most dangerous and the most to be condemned. Strongly recommended by some, their use is condemned with equal warmth by others, and numerous are the allegations brought forward against their use. Dr. Garel, whose exceptional experience enables him to speak with authority, says: "I do not know a single practitioner, although I know many highly skilled, who has not had a serious if not fatal accident with Graefe's basket. I myself have had several septic accidents, and I have long since discarded this dangerous instrument from my arsenal." Suppose, for instance, that we have managed to introduce the instrument and are proceeding to withdraw the foreign body. If the body presents the least asperity the *ensemble* realises the typical fish-hook. The instrument is apt to hitch against the cricoid, and operators are agreed that when this occurs the feeling is that the whole larynx would come away before the basket yielded. It is obvious that pulling on an inflamed, ulcerated œsophagus must be attended by the gravest consequences, and, as a matter of fact, death has resulted in a very large number of cases. Instances of the kind have been recorded by Lejars, Félizet, Piéchaud, Brais, and Sebileau. An instrument that is capable of setting up peri-œsophageal mischie and even of tearing the hilus of the lung must obviously be condemned. Some surgeons, it is true, still make use of it, supplemented by certain modifications of procedure. Félizet, for instance, introduces a sponge after the basket, which dilates the œsophagus and pushes the cricoid out of the way. Broca used to hook the cricoid out of the way with his index finger, and Jalaguier gives a quarter turn to the instrument so that its side comes against the cricoid and "does not catch." (?) Moreover the withdrawal of the instrument itself is not always easy, in short, taking a broad view of the subject as a whole, we do not hesitate to condemn its use even in recent cases and even for flat bodies free from surface irregularities. For such cases we prefer an instrument unprovided with winglets that "form harpoon" and the best is certainly Kirmisson's hook, though even then we should only make use of it in children within three days of the accident, and only if the family refused permission to perform œsophagotomy.

In these cases we should unhesitatingly recommend external œsophagotomy, a simple operation, much simpler in the child than is generally believed, simpler indeed than in the adult and it is also less dangerous than we might expect. We may incidentally refer to retro-thyroidian pharyngotomy, an operation that has been thought out by Quénu and Sebileau, but of which we have had no experience. It is available for the removal of bodies in the œsophagus as well as in the pharynx, but it seems to be a less direct way without appreciable advantage in the child. In the child foreign bodies in the pharynx can be removed by forceps and when lower down it is almost always at the lower part of the cervical œsophagus that they are to be found. This being so it is much simpler to go straight for them.

The œsophagus can be reached either through a median or a lateral incision, the latter being the one we ourselves have always preferred since it seems so much surer and simpler. It is best made on the left side, because on that side the œsophagus bulges more beyond the trachea and the recurrent nerve, situated in the tracheo-œsophageal depression, is more easily seen and avoided. Lieblein and Leriche, however, advocate making the incision on the side on which, as seen by the radioscope, the foreign body bulges most perceptibly. It is unnecessary to place a sound in the œsophagus if the coin be not lower than the sterno-clavicular line. Even in such case its introduction is by no means indispensable, and we run the risk of pushing the body further down and out of reach.

The incision is made along the anterior border of the sterno-mastoid, from the thyroid cartilage to the sterno-clavicular articulation. Having divided the aponeurosis and retracted the muscle, we get in sight of the omo- and cleido-hyoid muscles. Under the border of the omo-thyroid we divide the middle aponeurosis which is drawn inwards, along with the thyroid gland. The blood vessels are isolated and drawn to one side and the carotid region is then exposed to view. Above and below traction on the thyroid causes the thyroid vessels to stand out, and it is in the proximity to these two pedicles that we proceed to look for the œsophagus. The upper pedicle does not interfere with us much, but it is sometimes necessary to divide the lower one. All that remains to be done is to discover the œsophagus, carefully avoiding the recurrent laryngeal nerve. This is usually easy enough if we take the trachea as our guide, for between it and the vertebral column there is only the œsophagus. It is impossible to go astray, but it is useful to pass a grooved director along the cartilages of the trachea and so isolate the œsophagus which is drawn out to the left. It should be carefully separated from the trachea to avoid injury to the recurrent nerve, which indeed may advantageously be given in charge of an assistant. As a rule, the bulging of the œsophagus by the contained foreign body serves to identify the canal. The œsophagus, having been gripped by two Kocher's forceps, a small incision is made, not so small, however, as to expose us to the risk of a tear during the extraction. The foreign body is then seized with forceps, and carefully withdrawn, guided by the finger, making the necessary movements to secure its "delivery." Once out of the œsophagus, the body is cautiously led through the wound.

The edges of the incision are wiped with a plug of cotton, and having made sure that no other foreign body is present a few catgut sutures are introduced. It is but rarely that this suture can be made absolutely hermetic; it is in most instances a merely protective measure which, in certain fortunate cases, may become permanent. If the edges are irregular, or if the sutures cut through it is useless to persist, indeed we must esteem ourselves fortunate if we manage to get a few stitches to hold. The edges of the outer incisions are drawn together, always leaving a small drainage tube or strip of gauze at the lowest part. Should there be any collection of pus in the neighbourhood freer drainage will be required.

In no case is it necessary or desirable to leave in an œsophageal tube *via* the nostril, and it is dangerous to put one in the wound. We also deprecate the passage of a tube during the days following the operation.

During the first forty-eight hours no food whatever is given, alimentation being secured by rectal injections of serum. On the third day the administration of food by the mouth is resumed, indeed, it might advantageously be resumed earlier, for as with gastro-enterostomy certain patients succumb simply because they have not been fed early enough. The food consists of cornflour and similar concoctions, and there is no necessity to exert pressure on the œsophagus during the act of swallowing. On the fourth day the drain is taken away and on the eighth the surface sutures. In favourable cases, when the œsophageal suture has held, no escape of fluid takes place and recovery is rapid. Sometimes, at latest on the second day, a small quantity of fluid comes away through the wound, but if the drainage is effectual no harm results, and after a time the fistula closes unaided, though in one instance it persisted for two months.

This is the only complication—with the exception of —in one case—an attack of broncho-pneumonia—of œsophagotomy, and of our eight cases seven recovered promptly. Damage to the recurrent nerve can and ought to be avoided. But we are told that œsophagotomy may cause death in three manners—(1) by broncho-pneumonia; (2) by general septicæmia; and (3) by gangrene of the mediastinum. These accidents, especially broncho-pneumonia, which is given as the cause of death in a very large number of fatal cases, is, it cannot be too often repeated, less the consequence of the operation than of pre-existing alterations in the œsophageal walls. It may appear paradoxical, but the best way to prevent it is to perform œsophagotomy early in the course of events. As a matter of fact broncho-pneumonia has supervened before the operation was decided upon. The anæsthetic, it is true, might be incriminated as aggravating pre-existing pulmonary lesions, but inasmuch as it has to be employed even in the extraction by the mouth in young children, the danger is the same in the one case as in the other. The broncho-pneumonia in such cases has its origin in the blood, the infection gaining entrance through the ulcerations caused by the foreign body. Possibly the concomitant irritation of the recurrent laryngeal nerve may pave the way to this complication, but in no event is it a post-operative complication. In our own series of cases we only had one death in eight œsophagotomies, the little patient who was operated on the fourth day dying four weeks after operation with fever and symptoms of pulmonary congestion. Mr. Lieblein records a similar case which he operated on the day following the accident, yet the patient succumbed to capillary bronchitis soon after. This appears but too frequently the cause of death, and the rapidity with which the disease runs its course is calculated to cause surprise. On looking over the notes of these cases we cannot but subscribe to the opinion expressed by Dr. Mackay who asserts that "in the majority of cases death can scarcely be attributed to the operation," indeed we might without exaggeration, assert that in the fatal cases the patients died in spite of, and not by reason of, the operation.

Excluding one or two unfortunate cases in which death was the result of accidental infection, or operative mishap, it may be said that but seldom was death due to the œsophagus itself. If, moreover, we remember that the procedure is the only resource left to us in desperate cases, we are driven to the conclusion that in spite of certain discouraging statistics it remains an excellent operation, less dangerous than we are sometimes asked to believe, and comparatively easy of execution.

Moreover, in forming an opinion with regard to any operation, it is unfair to rely solely on general statistics, which necessarily comprise many dissimilar elements. Our own experience of œsophagostomy enables us to reduce the mortality from 22 per cent. (Balacesco and Cohn) and from 14 (Channac) to 12·5 per cent., a proportion which, though it may still appear high, is not so in reality if we bear in mind the precarious state of the subjects at the time of the operation.

We will conclude with a few suggestions concerning the operation. In the light of our present knowledge extraction by the mouth by the aid of forceps without the assistance of the œsophagoscope, is only admissible when the foreign body is within reach of the finger, or can be seen by the aid of the laryngeal mirror. Extraction by means of Graefe's basket, whatever precautions are taken, is often attended by fatal consequences, and must be condemned. Pushing the object into the stomach should only be attempted in presence of rounded, comparatively small objects, the diameter whereof does not greatly exceed that of the œsophagus, such bodies being of substances amenable to the action of the digestive juices and not of themselves toxic. Extraction by the aid of the œsophagoscope of recently swallowed rounded bodies may not improbably be the procedure of the future, in spite of the difficulties attending its application in children. However this may be, in view of the fact that foreign bodies almost always become impacted in children behind and rather above the sternal notch, the surest and safest mode of extraction in ordinary cases is certainly external œsophagotomy, practised at the site of election, and followed by suture of the muscles and temporary drainage at the lowest part of the wound. The broncho-pneumonia of which so much has been made is the consequence of pre-existing infection and has no connection with the operation.

Out-Patient Departments.

LIVERPOOL INFIRMARY FOR CHILDREN

A Case of Hypermetropia with Mental Symptoms.

By Hubert Armstrong, M.D., Ch.B.,Vict., M.D.Liv.,
Assistant Physician, Liverpool Infirmary for Children.

George A. P., æt. 4, was brought to the Out-patient Department of the Liverpool Infirmary for Children, his mother complaining that he had recently developed homicidal tendencies. Seizing an ordinary table knife or other light weapon, he had lately made frequent attacks upon his sisters, fortunately without any serious consequences, and now it was not safe to leave him unwatched.

The family history revealed no neurotic taint, his past history was unimportant in connection with the present phase, and a careful examination of the child disclosed nothing but a well-developed, fair-haired, intelligent boy, with no signs of disease except a slight growth of retro-nasal adenoids. The refraction, however, was not then tested. Subsequently he was found to be infected with thread-worms, which were treated effectually, but without altering his excitability. After general treatment for some six weeks his symptoms changed their type, for the boy now became increasingly stupid and sleepy, at the same time developing an internal strabismus of the right eye, at first transient but rapidly becoming permanent. There was no optic neuritis, and this being so I then referred him to Mr. T. H. Bickerton, ophthalmic surgeon to the Royal Infirmary, with the request for an opinion on his refraction. Mr. Bickerton reported: "The child has high hypermetropia, + 6 D. in each eye. I have ordered + 6 D. to be worn always. They should entirely cure the squint and must be a great relief. It would be very interesting if his symptoms did entirely clear." Shortly, that is what took place. Within a fortnight after beginning to wear the spectacles the boy was himself again, passing from his dull condition to his normal brightness without any recurrence of the murderous propensity which had intervened on the down grade. The squint, however, took somewhat longer to right itself than did the mental symptoms. At a later date the adenoid growths were removed, and after reporting himself once or twice at extending intervals, the boy ceased attendance.

Remarks.—The part played by errors of refraction in the causation of what had previously been termed "functional" diseases, and even in the production of symptoms of organic disease, is daily obtaining greater recognition. In a recent paper (*Lancet*, I., 1905, p. 1,537) Pronger has related cases of grave and prolonged neurasthenia cured by the correction of even the slightest grades of astigmatism As a cause of headaches and migraine hypermetropia and astigmatism have now long been recognised by the profession, though to convince a patient, who thinks he sees perfectly, of the utility of consulting an oculist is still often a matter of difficulty. Many a poor child in this city continues suffering from headache because its parents consider a pair of spectacles a poor substitute for the bottle of physic they expected. Again, no case of epilepsy, at any rate in the young, can be considered adequately treated until, in common with any other peripheral source of cerebral irritation, the possibility of ametropia has been eliminated or its presence corrected. Various forms of dyspepsia are amenable to treatment by suitable glasses, and the list of diseases in which attention to the eyes is an important element in the therapeutics might be legitimately extended without encroaching upon the prerogatives of those enterprising so-called "optologists," with whom "eye-strain" is at once the cause of most diseases, and a captivating phrase wherewith to bait their alluring advertisements.

In the case related above we have the curious symptoms of homicidal mania, which the mother stated made her child "without exaggeration a terror to the household," followed later by a stuperose condition, disappearing completely and immediately upon the correction of high hypermetropia.

Actual insanity in the young is not so rare as is sometimes imagined (McLane Hamilton, *Medical Record*, 20, VI., '03) apart altogether from congenital idiocies or epileptic breakdown. Insane children at times have obsessions, and an impulse is the first evidence of the mental mischief. Generally when homicidal acts are committed, there is found an absence of the moral sense, and in practically all such cases defective heredity, with or without a vicious environment, will be discovered to be the principal factor in the etiology of their degenerative condition. In my patient all these could be absolutely excluded. Though headache was never a symptom, on the occasion of one visit I detected an irregularity of the pulse, and I had been suspecting the onset of tuberculous meningitis, in the prodromal and first stages of which disease various mental perversions are occasionally encountered. However, although the appearance of the squint at the first glance seemed to fortify this diagnosis, it was really that, with the absence of changes in the optic disc, which on its occurrence at once supplied the clue to the true condition.

Special Articles.

ANNUAL REPORT OF THE IRISH PRISONS BOARD.

The twenty-seventh Report of the General Prisons Board, Ireland, recently issued, does not contain much matter of a purely medical interest. The health of the prisoners has been on the whole good, and there has been no outbreak of infectious disease. In fact, the only zymotic disease which runs into two figures in the statistics of incidence is influenza, from which Mountjoy, co. Waterford, and Maryborough prisons suffered heavily. The number of cases of phthisis treated during the year is remarkably small—19. Apart from executions, there were only 8 deaths during the year; one of these was from rupture of the heart in the case of a prisoner awaiting execution, and another was from perforation of the intestine in typhoid fever. The list of diseases treated during the year is blank, as regards cancer, though elsewhere in the Report we learn that one death was due to cancer of the liver; care should be taken to avoid errors of tabulation of this sort. Twenty prisoners were released during the year on medical grounds.

Viewed from the social aspect, it is very satisfactory to note the continued decrease of serious crime in Ireland. One prison (that at Wexford) has been closed during the year, thus reducing the 42 which existed at the passing of the Prisons Act in 1877 to 19. It is hoped, moreover, during the current year to close the Limerick Female Prison. The number of local prisoners has remained fairly constant for the past few years, but the number of convicts is remarkably small. Whereas there were on January 1st, 1855, 3,427 convicts in custody, and in 1870, 1,230, there were on January 1st, 1904, only 252. Of these only ten were women.

The industries in which prisoners are employed are very varied, including baking, brush-making, carpentry, cutting firewood, mat-making, knitting, needlework, sack-making, shoe-making, smithing, stone-breaking, tailoring, washing, weaving of matting, frieze, linsey and blankets, mail bag-making, and cutting of linen for paper-making. Only a daily average of 163 was employed in picking oakum. It is intended, we are glad to note, to extend as much as possible the principle of associated labour, and the Prisons Board are at present erecting large workshops in Mountjoy.

The number of inmates of the State Inebriate Reformatory at Ennis has been during the year a little over thirty. It is unfortunate that more use is not made of this institution, as experience up to the present gives, in the case of those who have undergone prolonged sentences, gratifying evidence of the beneficial results of the treatment. On this point the Board remarks :—" As it has now been clearly proved that the Reformatory treatment has in many cases succeeded beyond expectation, it is a matter of much regret that more of the habitual inebriates for whom the institution was established are not sent there, and also that in the cases of some of those who are sent, the term of committal is so short as not to afford a fair opportunity of applying the remedial influence of the Reformatory. There was an improvement shown in this respect last year, as compared with 1903, inasmuch as while in 1903 three sentences of less than eighteen months were passed, only one such was passed in 1904. This latter, however, was for the very short term of six months, a period in the opinion of all those who have any experience of the institution, altogether too short."

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, October 1st, 1905.

The Treatment of Syphilis by Light, Especially Iron Light.

A **paper** on this subject recently appeared from the pen of Dr. Brieger in the *Monatssch. f. Orto. Chir.*, 7.05. He records six cases in which both mercury and potassic iodide failed to give any useful result. The iron light alone was used, aided by the dermo and triplet lamp. The sittings took place daily, at first for from three to five minutes, later on gradually lengthened to twenty-five to thirty minutes.

The cases were an extensive syphilide of the forehead and hairy scalp, a papulous eruption of the forehead, ulcerations of the face with extensive defects on the alæ nasi and the left lower eyelid, an ulcer of the mucous membrane of the lower lip, two cases of plaques on the mucous surfaces of the mouth, tonsils, the soft palate, and the genitals. In some cases the iron light treatment was associated with blue arc light baths.

From further cases in which the light treatment was combined with hg. and iodine treatment, and in which the syphilitic diseases of the skin and mucous surfaces healed much more rapidly and with less formation of cicatrices than hg. and iodine alone, he is of opinion that proof is furnished of the leading part that light played.

As regards the results obtained in the different forms of disease, he reports that soft chancre generally healed readily under iron light, and that new ulcers very rarely formed. As soon as the base of the ulcer was cleaned and healthy granulations formed, a few applications of rich carbon light completed the healing. Indurated chancres were equally well influenced by the iron light, but they took longer time to heal. The syphilitic diseases of the mucous membrane of the mouth he treated with the iron light of the dermo and triplet lamp; this was also used on the diseased genitals. All the syphilitic eruptions of the skin he treated exclusively with the dermo-light projector, which permitted of large surfaces being treated at once.

He recommends that the local treatment shall be combined with general and for those for whom incandescent light baths are preferred he suggests the employment of the arc light for, as a rule, the cases suffer from physical debility. Arc light baths have shown themselves the most effective, as in cases of inunction treatment they have assisted in the excretion of the mercury; they possess the properties of exciting tissue change, of improving the blood and increasing the antitoxins.

He has also repeatedly succeeded in curing chronic gonorrhœa by the blue light of the carbon light-projector (Kohlenlicht scheinwerfer).

Peroxide of Hydrogen as a Milk Preservative.

Dr. Ernest Baumann, of the Hygienic Institute, Hale on S., has given us a paper on this subject in the *Munch. Med. Wochensch*, 23·05. He says that if added to milk in a proportion of 0·35 per cent. it has strong bactericide powers over the disease germs that are liable to be disseminated though milk—*i.e.*, the germ of typhoid, cholera, dysentery, and tuberculosis. It has the property of being perfectly indifferent as regards the human body, being merely split up, on being taken into water and oxygen; no danger to health, therefore, need be feared from its use. The taste of the milk is said not to be affected by the addition of the preservative.

Apart from its value as regards the feeding of children, it is well adapted for use in the field, the navy, and in tropical regions. For practical use it is indispensable that the peroxide should be added immediately after milking, and before any increase of germ can have taken place. In order to prevent any undue letting down of the milk he suggests the use of a 33 per cent. solution. The milking also must be done in the most cleanly way possible, the cow's udder and teats must be always cleansed beforehand, the hands washed, none but sterile vessels to be used, &c. The few germs that may be present or that may find their way, in spite of all precaution, will be certainly destroyed, he tells us, by the peroxide of hydrogen.

The Therapeutics of Veronal.

This hypnotic, recently introduced by Emil Fischer and J. Von Mehring, has already met with a considerable amount of favour among the medical profession. The dose is smaller than that of trional, which it resembles most in its action. It possesses another advantage over trional in that it is moderately soluble in boiling water, *i.e.*, to the extent of about 1 in 12. Extensive experiments on animals show that it is relatively non-poisonous. When given in large doses, voluntary movements first cease, then comes on a stage in which respiration is diminished; the temperature is reduced, so are also reflex movements. In the animals experimented on the lethal dose was 0·7 grm. per kilo (nearly 1½ oz. for a man of 10 st.).

The relative non-poisonous character of the drug is also shown by cases recorded of attempted suicide by it, in which as much as 9 grms. have been taken at once, with complete absence of threatening symptoms.

The hypnotic effect of veronal is supposed to be due to a paralysing effect on the central nervous system, that in small doses gives evidence of itself in sleep, in larger ones in prostration. The drug sets up no spasms, and is without effect on nerves and muscles. It does not change the character of the blood, nor the blood pressure, nor does it affect the liver or kidneys, although it is said to increase the kidney excretions. In consequence of its diuretic action it abates the night sweats of phthisical patients, and probably in this respect it resembles its rival, trional. Experiments made with a view of ascertaining its effects on the heart were favourable. It did not reduce cardiac activity in power; it may therefore be given with confidence in cases of cardiac insufficiency.

According to the investigations of its introducers, Fischer and Von Mehring, veronal is not decomposed in the body, but to the extent of 70 per cent. passes unchanged through the kidneys.

It has no injurious effect on the gastric or intestinal functions even when dyspeptic symptoms are present; on the contrary, many observers declare that the body weight always increases under its use. This being due to its action as a “ sparmittel ” in regard to albumen.

It is also very useful in epileptic conditions, epileptic excitement, insanity, mania, and the nightly spasmodic attacks of epileptics. In such cases it can frequently be substituted for bromides with advantage. In chorea minor it has also proved successful in cases in which large doses of bromides have failed. A combination of morphia and veronal has frequently proved effective in doses in which both have failed when given singly. It is said that morphia, when thus given in combination, with veronal, is not liable to bring on the morphia habit. This statement, however, remains to be confirmed.

It is best given in hot tea, or valerian tea, peppermint tea, or wormwood tea may be made the vehicle, as these teas have a calmative influence on the intestinal tract.

In order to prevent its too long retention or accumulation in the system, some saline purgative should be given occasionally, and it is also well to bear in mind that several observers have seen acute dermatitis with excessive pruritus follow its use, but never until after the fourth successive evening dose. Finally, in action it is not so rapid as that of trional.

Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, October 1st, 1905.

Fruitosuria.

Neubauer has raised a new difficulty in our diagnosis of saccharine urine. From animals he has passed to the human subject, and finds that when fed with fruit the urine becomes saccharine. If the diet be “ disaccharid,” or deprived of fruity or cane sugar, the elimination of sugar ceases by the urine. Grape sugar, sugar of milk, and amylum produce the same phenomenon when no diabetes or its allied congenitors, obesity and gout, are present. He maintains the case is different when there is a mixed mellituria, as he finds the sugar of the fruit is all burned up, although grape sugar may pass through the body unchanged or may be eliminated as fruity sugar, which he interprets as a partial metabolism of the sugar in the body.

Radical Cure for Prostatic Hypertrophy.

Rebentisch warns the profession against the notion of freely accepting the operation of prostatectomia perinealis or prostatectomia suprapubica as innocent and free from danger. When the kidneys are healthy, the risk is certainly small, but these are usually damaged before the operation is undertaken. When early under observation, these symptoms of painful catheterisation, hyperesthesia, or complications such as cystitis, hæmorrhage, or exhaustion should determine the operation.

The suprapubic after Freyer's method is the least dangerous and most successful. When the swelling is a small hard tumour, the perineal operation may be preferable.

Bottini's operation may be undertaken when the patient cannot bear a general narcotic or where the tumour has become malignant.

Red Rays in Scarlatina.

Cnopf has been engaged in the application of the red rays in scarlatina, and affirms that the initial stage is greatly benefited by their application. The dermatitis and temperature are both notably reduced by their administration.

Bladder Skiagraphs.

Volker and Lichtenberg fill the bladder with 120 or 150 grams of a 2 per cent. lotion of collargol, which gives an excellent outline of the organ when the Röntgen rays are applied. The normal form is like a pear, shorter and broader in the upper part in females. In the multipara it is asymetrical, especially when there is prolapse of the uterus or walls of the vagina. In prostatic hypertrophy the lower part of the pear-like shape is flattened. The tuberculous bladder is broad and short from below upwards.

Indican Test in Urine.

Gurber adds another handy test for indican to the number, but can only be used as a qualitative test and not quantitative. Take a test tube with a third of urine, add twice as much concentrated hydrochloric acid with two or three drops of a 1 per cent. solution of osmic acid; then mix well, when a violet or blue-violet colour will appear according to the amount of indican present. This could be compared with a corresponding quantity of indigo blue in chloroform. Although it is a handy test it will not supersede Obermayer's more accurate determination of quantity.

Blood in Fæces.

Siegel affirms that the guaiaco-turpentine, or, better, the benzidin test, is sufficient to detect small quantities of blood in a solution of fæces, when taken shortly after emission. A solution of blood, when allowed to stand exposed to the air, undergoes a chemical change, and loses the power of transmitting the ozone by means of the turpentine to the guaiccum. When this test fails, though a meat diet has been indulged in, we may be pretty confident that no hæmorrhage is present. This may be verified by means of the aloin test or the spectroscope.

Doubtful Glandular Affection.

Moebius relates a curious case of glandular changes, who died, but the *post-mortem* added no more light to the cause of death. The case was an elderly female whose sister died of morbus Basedowii. The patient first began to emaciate, associated with great feebleness, tachycardia, with slight mental disturbance. Iodide was given, which acted as a toxine and aggravated her whole condition.

At the commencement of the illness the lymphatic glands were enlarged, but the thyroid appeared unaffected. The disease seemed to be of a chronic nature, and ended in intercurrent apoplexy.

The *post-mortem* examination was equally barren; no satisfactory cause could be given.

Spirochaete Pallida in Syphilitic Blood.

Staehlein and Noegerath have been hunting for the spirochaete in blood, and find it present only in syphilitic conditions. Their mode of search is to take one cubic centimetre of blood from the lobe of the ear and dilute it ten times, adding a little of ½ per cent. solution of acetic acid and thin centrifuge. From the deposit preparations are obtained and coloured by Gremsa's method to show the vibrio. In three secondary syphilitic cases the spirochaete was present, while in other six healthy cases the vibrion could not be found.

Typhoid Bacilli.

Forster and Kayser appear to upset much of our theory concerning the transmission of the typhoid bacilli. Several cultures taken from the gall of typhoid patients led them to experiment on animals, which confirms the fact that the bacilli are invariably to be found in the gall-bladder, which has led them to believe that the bowel is infected from the bile passing into the intestine. A series of *post-mortem* cases have since been examined, and everyone had the gall-bladder richly strewn with the bacilli, which they maintain were the primary focus of the lethal disease. No conjecture is yet offered as to how they first settled there. Did the liver secrete them from the blood?

Hungary.

[FROM OUR OWN CORRESPONDENT.]

Budapest, October 1st, 1905.

At the recent meeting of the Budapest Interhospital Association, Dr. Kasper recommended an ideal lubricant for catheters and sounds consisting of a mixture of glycerine water and tragacanth, together with mercury oxycyanate (1 in 500). This does not irritate the urethra, renders the instrument very smooth and slippery, is readily soluble in water, and dissolves as soon as the instrument is inserted into the bladder, without obscuring the view through the cystoscope. In place of boric acid for washing out the bladder he prefers mercury oxycyanate (1 in 5000). This is non-irritating, does not injure the instruments, and although not a strong antiseptic is yet sufficient to inhibit the growth of microbes. His method of sterilising catheters and cystoscopes is as follows:—The parts are rubbed with three gauze sponges dipped in tincture of green soap, using each one for a minute. The instrument is then wrapped in a compress impregnated with the same material and kept in this until needed. Whatever parts can be removed are boiled for five minutes.

Dr. Rehn spoke in severe criticism against the practice, becoming more and more common, of deciding upon operation in appendicitis, from the number of leucocytes in the blood. If it is certain or probable that the appendix is in an inflamed condition, it should be removed without delay. Daily blood-counts will never give a clue as to the true pathological condition, and they may jeopardise the patient's life, as valuable time is lost. Curschmann, who inaugurated the practice, states that more than 25,000 leucocytes indicate pus, but Rehn has found that a large abscess may be present both in early and in less recent progressive cases, with much lower figures.

RADIUM.

Dr. Traczi gave an interesting résumé of the properties of radium. It appears that this wonderful substance is capable of emitting three kinds of rays. Cathode and Röntgen rays, and rays due to positively electrified true atoms. Their combined effect resembles the X-rays closely, but it takes a much longer time to take a photograph similar to a radiograph. It has been proved satisfactorily to medical men that radium salts have a positive effect upon diseased tissue, and even at this early stage it looks as if their use were indicated in lupus and other forms of tuberculosis, rodent ulcer, and some cases of deep cancer in chronic skin diseases, atrophy of the optic nerve, and blindness from other causes. The radium rays give more promising results in these conditions than other rays.

At the recent autumn meeting of the University Board of Medical Examiners, surprisingly few applicants were successful, the failures reading 35 per cent. One man was expelled for cheating, and many withdrew. Members of the Board stated that the large percentage of failures was due to the severe examination which was made more difficult than ever.

Operating Theatres.

FRENCH HOSPITAL.

Operation for Gastric Ulcer.—Suture of Ulcer.—Gastro-jejunostomy.—Lateral Anastomosis.—**Mr. Clayton-Greene** operated on a man, æt. 54, who had been re-admitted to the hospital eight days previously. Six months before, the patient had been taken into the hospital suffering from malnutrition and dyspepsia. At this time the man stated that he had been troubled for two years with pain, flatulence, and other dyspeptic symptoms, including occasional vomiting, but no hæmatemesis; as a commercial traveller, his meals had been irregular and of poor quality. He remained for three or four weeks in the hospital, and, as his condition was much improved, he went out. On re-admission, six months afterwards, he was seen to have facial emaciation and slight jaundice; he had eaten very little since leaving the hospital. He had vomited a little almost every day, and the pain and distension after food had gradually increased; he complained of great pain in the abdomen, and more especially in the pit of the stomach; he vomited mucus streaked with bright red blood, small in amount, but there was no altered blood. The abdomen was very rigid and moderately tender, but not exquisitely so. Palpation was impossible on account of the rigidity. There was no melæna, and the bowels acted. The vomiting subsided gradually, and he began to take small quantities of liquid nourishment; the pain also largely disappeared, excepting for slight tenderness in the right epigastrium. As no progress was made as regards solid nourishment, an operation was decided upon. The patient having been anæsthetised, an incision was made from the xiphisternum to the umbilicus. On opening the abdomen, about ten ounces of peritoneal fluid escaped at once. The liver was found to be enlarged, and on turning aside its lower edge an ulcer was discovered on the lesser curvature in the pyloric third of the stomach. The centre of the ulcer was necrotic and perforated. The ulcer was then buried by a first series of catgut Lembert's sutures, and a second series of silk Lembert's sutures. The next step of the operation was to perform gastro-jejunostomy. A suitable loop of jejunum was selected and a cone of stomach picked up on the posterior aspect of the great curvature; this was then pulled through the transverse meso-colon and united to the loop of jejunum by two series of sutures; no Murphy's button or bobbin was employed. Finally, an anastomosis was made between the adjoining limbs of the loop of jejunum which had been joined to the stomach. The opening into the peritoneum was closed by deep silk continuous suture; an interrupted suture was made to unite the aponeurosis, and finally a series of silk-worm gut sutures was employed to bring the skin together. The operation lasted one and a half hours, but the patient stood the operation and anæsthetic well. On reaching the ward a large enema, consisting of normal saline, brandy, and strong coffee was administered. Mr. Clayton-Greene remarked that the points of interest in connection with the case were: (1) *The Diagnosis.*—The patient was generally considered to be suffering from gastric carcinoma. His aspect, the profound anæmia, and the emaciation favoured this view. On the other hand, the marked rigidity of the abdomen, the sudden attacks of pain from which he suffered, were against this suggestion. No definite tumour could be felt. The man had been a heavy drinker, and had been infected with syphilis, so that the possibility of hæmorrhage from cirrhosis of the liver was a matter for consideration. On the whole the symptoms suggested an ulcer, and from his age, sex, and from the situation of the pain, and from the marked rigidity of the right rectus, the seat of the ulcer was thought to be the duodenum. On opening the abdomen, the rush of serous fluid at once made him think of carcinomatous growths on the peritoneum. There were none to be felt. The liver, which was enlarged, extended down to the umbilicus, and was covered with a number of recent friable adhesions. On breaking these down a flake of lymph the size of a shilling was found between the stomach and the under-surface of the liver, and at once suggested the lymph round an ulcer. On lifting the liver up, the ulcer was found close to the lesser curvature, perforated, but shut off by adhesion to the liver, so that there had not been extravasation of the gastric contents. The perforation was evidently recent, and was no doubt the cause of the last acute attack which brought the patient back to the hospital. It is, he pointed out, somewhat unusual to meet with this condition in a man of 54. There was no evidence of the ulcer being malignant, that is all he could say. The age suggested that malignancy was probable, and for that reason he would have much preferred excising the ulcer freely.

However, in the weak state the patient was, Mr. Clayton-Greene doubted if he would have stood the very extensive operation that would have been required for that purpose. (2) *Treatment.*—Excision of the ulcer would have been the ideal treatment, but owing to the size and encroachments of the liver, and the fixation of the stomach, he did not think it feasible. There had been some old inflammation at the back of the stomach, and it was much less mobile than usual. Indeed, the mere suturing of the ulcer was, he considered, the most difficult part of the operation, and took at least thirty minutes. After the suturing a posterior gastro-enterostomy was performed. During this step great trouble was experienced owing to the fixation of the stomach, and it was only after some difficulty that a suitable cone could be drawn through the transverse meso-colon. Catgut was used for the through and through deep-stitch, No. 1 silk for the seromuscular. There was no bleeding. The limbs of the jejunal loop were anastomosed subsequently. This, he thought, was an important step as it must effectually prevent any tendency to the regurgitant bilious vomiting. The only argument against it, he remarked, was that it adds ten to fifteen minutes on to the duration of the operation. This is an undoubted drawback, but the advantages, he thought, outweighed this objection. It is true, he said, that among the long lists of published cases, regurgitant vomiting has rarely occurred, no cross anastomosis having been used; but in a number of recent cases he had seen it sufficiently often to make it worth while to provide against the contingency. During the operation, hot saline was poured freely over the exposed viscera. A small drain was passed through a separate opening in the abdominal wall up to the region of the sutured perforation.

The patient stood the operation well. He was sick slightly during the night, started taking food (bouillon) next day, and has given no cause for anxiety in any way. All the rigidity of the abdominal wall has disappeared, there is no pain, and the bowels are acting naturally. The drainage tube being functionless has been removed.

The Opening of the Dublin Medical Schools.

THE Winter Session of the Dublin Hospitals and Medical Schools nominally opened on Monday last, and in all cases work will be in full swing in ten days or a fortnight's time. Several of the hospitals have abandoned the practice of commencing the session by an address to the students, but in many this excellent practice is maintained. In the present session the Meath Hospital is the first to commence, and on the 9th instant an address will be delivered by Sir John Moore. This will be followed by an address by Dr. Cox at St. Vincent's Hospital, on the 10th, and by an address by Dr. W. J. Thompson at Jervis Street, Hospital on the 17th.

The Central Midwives' Board.

AT a meeting of this Board, to be held to-morrow (Thursday), Mr. Ward Cousins will move: (1) That the resolution of the Board of March 23rd, 1905, refusing the request of the Belfast Maternity Hospital for the recognition of its certificate as an approved qualification under Section 2 of the Midwives' Act, be rescinded. In the event of the above resolution being carried (2) That the application of the Belfast Maternity Hospital for the approval of its certificate as a qualification under Section 2 of the Midwives' Act be granted.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, OCTOBER 4, 1905.

CAUSES OF DIARRHŒA AND TYPHOID FEVER.

IT has often been pointed out that whereas the epidemic diseases of winter and spring affect primarily the organs situated above the diaphragm, those of the summer and autumn attack the viscera situated below that structure. Everyone knows that he is more likely to get a cold in the head, a sore throat, or an attack of bronchitis in the winter, and to suffer from vomiting and diarrhœa in the summer. Now, whatever may be the causes of the cold-weather diseases, it is natural to attribute a share at least of the warm weather ones to articles of food and drink that are received into the body. Doubtless there are many contributing causes, such as debility, chill, idiosyncracy, exhaustion, which go towards the determination of an illness, but the fact remains that the exciting causes of diseases which affect the stomach and intestines, are to be found in some morbid or improper quality in the ingesta. The two chief warm-weather diseases that prevail in this country are typhoid fever and epidemic diarrhœa, and both these are known to be directly incited by infections of the lower alimentary tract. In the case of simple diarrhœa a sufficient explanation is usually furnished by mechanical or chemical irritation of the intestinal mucosa by indigestible substances, or the juices of decomposed fruit, or poisons generated by putrefactive bacteria in tainted meat, but in epidemic diarrhœa and typhoid fever there is superadded the element of direct infection of the intestine by specific bacteria. Typhoid fever possesses its own organism, or, according to recent researches, its own group of allied organisms, which alone are capable of inducing the disease, but epidemic diarrhœa seems to be caused by several different bacteria, according to time and circumstances. The chief of these, according to the latest work appears to be the *Bacillus dysentericæ* of Shiga and Kruse, for it has been isolated from the stools of patients suffering from diarrhœa in quite a number of epidemics in the last three or four years, but besides it there is no doubt that *Bacillus coli* is sometimes the causative organism, and probably in certain cases *Proteus vulgaris* and streptococci act also as primary or secondary agents. These facts being now fairly well established it becomes a matter of the highest importance to determine by what means they find their way into the intestine, for both epidemic diarrhœa and typhoid fever take an annual toll from the population which it can ill spare. That typhoid fever can be induced by direct contamination of water or milk supplies by typhoid excreta is sufficiently well-known, and that epidemic diarrhœa is caused by contamination of milk by the etiological organism is, or should be, sufficiently apparent from the evidence accumulated by inquiries conducted of late. At Stockport, for instance, in 1903, out of 1,960 breast-fed children, only two died of diarrhœa, while of 840 bottle-fed ones, no less than 59 perished of the complaint—a fatality seventy times that of the breast-fed ones. Figures such as these leave no doubt that the fault lies in the food, and in the case of an infective disease in the bactérial condition of the food. The search, then, must be directed to those agencies whereby food becomes infected. In the case of typhoid fever, attention has been directed so much towards water-supplies—though not more than their importance warrants—that other agencies have been liable to be overlooked, but the case against shell-fish and watercress as typhoid producers has now been abundantly made out, and it remains to be seen what other articles of food must be suspected. In diarrhœa attention must naturally be concentrated chiefly on the means whereby milk is liable to become infected. Leaving out of account the abundant opportunities for this to occur in the passage of milk from the cow to the consumer, we may note that a special explanation is needed for the annual rise in the diarrhœa-curve during the warm months, for there is no reason to suppose that any greater laxity—if that be possible—in milking and milk-conveying arrangements exists in the summer than in the winter. It has been pointed out by several observers, notably by Dr. Martin and Dr. Nash, that the rise in epidemic diarrhœa corresponds very closely with the prevalence of the common fly, and it has also been shown that Ballard's classical rule that the rise in diarrhœa does not take place till the 4-foot earth-thermometer has reached 56° F. is not invariable, and that there are other factors besides temperature—notably, of course, moisture—which influence diarrhœa epidemicity. Moreover, the increase of typhoid fever, though following that of diarrhœa, may to a certain extent be referred to similar causes if the lengthy incubation period of the former disease be taken into account. It is not easy on a purely water-borne or milk-borne theory of typhoid and diarrhœa to account for the fall in the prevalence of the diseases which follows the introduction of a water-carriage system of sewerage into a town, whose water-supply remains the same. Now, not only has such a fall often taken place, but if an agent is assured which is capable of transferring infection from privy-middens and pails to articles of food and drink, the explanation is at once forthcoming. It would be possible to refer to several localised outbreaks of typhoid fever and diarrhœa which have followed unusual prevalence of flies in certain districts, due to certain particular conditions which favoured breeding, and there is still before us the strong testimony of medical officers with the army in South Africa with regard to the relation of flies and typhoid fever in the campaign against the Boers. Majors Horrocks and Firth have shown by experiment that the fly can mechanically convey typhoid bacilli after feeding on excreta, and it requires no stretch of the imagination to conceive how easily food and drink could become infected by their agency. Evidence is steadily accumulating against the fly being to temperate climates an agent hardly less important than the mosquito to hot ones.

A YEAR'S LUNACY.

Alarmists and quidnuncs who live on the sensation of the day are never happier than when they can refer to a fresh increase in lunacy, for such increase can be brought in to support any pet fad from vegetarianism to antivaccinism. But to those who delight in finding fresh evidence of the moral and social obliquity of their fellows, we would commend a careful perusal of the 1904 report of the Commissioners in Lunacy, which has just been published. We do not mean to say that this Blue Book is exhilarating reading, but the facts it reveals go a long way towards discounting those loose and sweeping generalisations which are easily made and with difficulty disproved. There has been a slight increase as compared with 1903 in the number of the insane under certificate, it is true, but the increase is small and confined almost entirely to one class, namely to those under care in county and borough asylums. Of the other classes of the insane, there were only seven more in private asylums, sixteen more under single care, nineteen in workhouses, and forty-six outdoor pauper lunatics, whilst the criminal lunatics at Broadmoor were the same in number as last year. The additional number confined in county and borough asylums amounted to 2,542, a fact which is regrettable enough in itself, but is to be taken in conjunction with various considerations to be mentioned. It is to be observed that these figures refer to total numbers under treatment, and as the death-rate among the insane is low owing to the care lavished on them in public institutions, and the recovery rate is not likely to vary very much, it is not to be expected that a balance in outgoings and incomings will be established for many years unless some large and unlooked-for factor steps in. But the satisfactory feature is that the rate of increase of lunacy shows a marked abatement as compared with the previous year and the previous decade. Thus, among private patients the increase is less by 139 than in 1903, and by 50 than the average of the last decade, and, as the Commisioners explain, the whole of the increase in private lunatics is due to the fact that their friends prefer in many cases to have their patients transferred from the pauper class to the private one. The numbers of pauper patients show an increase less by 471 than was the case in 1903, but of the total insane, as compared with population, the Commissioners find that whereas on January 1st, 1903, there was one lunatic to every 288 persons, on January 1st, 1904, there was one to every 285—a slight increase which, though in itself unsatisfactory, is due to a certain extent to classification. But when we turn to admissions we find a more hopeful picture. Taking first admissions, we find that there has been a fall of ·10 per 10,000, namely, from 5·50 to 5·40. Even taking admissions and re-admissions, there were actually 75 fewer patients received than in 1903, and the fall is practically confined to the pauper class, private and criminal cases remaining the same. A significant fact to which the Commissioners draw attention is that there is a growing tendency to send people who are over sixty-five and are suffering from senile mental troubles into asylums. Thus, whereas in the quinquennium 1884-8 these old people formed 9·9 per cent. of admissions, in 1899—1903 they accounted for 14·3 per cent. Quite rightly the Commissioners regret this tendency. No doubt a proportion of cases of senile dementia are better under asylum care, but a large number of them are more suited to the benevolent ministrations of their friends in their declining years, or, if paupers, to those of the guardians. Admitted to asylums, they greatly increase the tax on the accommodation, and they can seldom be hoped to benefit in any way by treatment. And, after all, the great object of the present-day elaborate and costly asylums ought to be to restore function to a diseased organ and body, rather than to act as a home for harmless incurables. The recovery rate in 1904 was somewhat lower than in 1903, but amounted to the respectable total of 37·67 per cent. on the total admissions, and in this and all the foregoing calculations the number of old people now certified must be borne in mind. In seeking to judge of the numbers of the insane, and their proportion to the healthy of the community, it is to be constantly noted that now that asylums are palaces rather than zoological gardens, and the stigma of lunacy is not what it was, certification is far more readily adopted than formerly, and friends have less and less compunction to having their inconvenient relatives "put away." A testimonial to the salubrity of asylums is furnished by those parts of the Commissioners' report which deal with general health and deaths. The death-rate, calculated on the daily average of residents, is only 9·95 per cent., a slight fall from the 10·20 per cent. of 1903, and the bulk of the deaths were referable to general causes, such as overtake those who pursue the ordinary avocations of life. Society may or many not congratulate itself on the death-rate of Broadmoor, which was only 2·12 per cent., but it may at any rate plume itself on its humanitarianism in treating its most dangerous enemies with so lenient a hand. It is satisfactory to note that infectious diseases caused but little inconvenience to asylum communities, and especially so that dysentery was distinctly less rife than in the previous year. The inadvisability of aggregation as a factor in the treatment of the insane, as in all other human affairs, is shown by the tables presented by the Commissioners, comparing the incidence-rates of dysentery and the death-rates from tuberculosis in asylums of large, medium, and small size. Those in the latter group exhibit by far the most favourable returns. Taken as a whole, the Commissioners' report is the brightest and most hopeful we have read.

MONOTONY IN PRESCRIBING.

THE administration of drugs, like other branches of practical medicine, is undoubtedly undergoing a species of evolution. It has gained in accuracy and efficiency by the enormous strides that have been made in our modern knowledge of materia medica. At the same time, nevertheless, the developments of surgery have cut deep into the faith that was formerly attached to the efficacy of drugs. This attitude of doubt and interrogation has been further emphasised by the clearer insight into the intimate causation of many morbid conditions afforded by the science of bacteriology. In spite of the profound alterations in the treatment of disease that have been brought about in the foregoing and in other ways, there yet remains a great margin of symptomatic and obscure ailments which come within the province of the physician to alleviate or to cure. In other words, medicine has not yet attained the footing of an exact science, and its disciples have still to trust in many instances to a more or less purely empiric art. The practitioner of to-day is furnished with so vast an armoury of remedies that he may well be excused for dismissing the majority of them with scant courtesy, while he confines his practice to the changes rung upon a score or so of well-tried and familiar medicaments. The attempt to cut the Gordian knot in this fashion, however, is likely to curtail the success of the practitioner. In any case, he will do well to consider the advisability of adding a little variety to his prescriptions for his own sake as well as for the benefit of his patients. His attention may be drawn to an interesting communication on this subject published in the correspondence columns of the present issue of THE MEDICAL PRESS AND CIRCULAR (page 362). This letter in question is from the pen of Dr. William Murrell, who is peculiarly qualified to speak with the voice of authority upon anything pertaining to materia medica and therapeutics. The gist of his contention is that medical men are wont to drift into a purposeless and enervating monotony in prescribing. His main illustration is taken from tincture of nux vomica, which some years ago was shown to be ordered more frequently than any other drug or preparation as the result of an analysis of over 25,000 prescriptions. Nowadays the man in the street is so universally intelligent that he has a nodding acquaintance with most of the drugs in common use. There is a great deal of force in Dr. Murrell's contention that the patient who finds nux vomica in every prescription quite irrespective of the nature of the ailment from which he may be suffering, is apt to lose faith in the originality of orthodox members of the profession, and to drift into the hands of quacks. The matter, so far as that goes, might be put much more forcibly. The difference between the skilled medical man and the quack is that the scientific man commands a host of remedies with understanding and adaptation, while the charlatan, simply and sheerly by rule of thumb, uses a few drugs of which he knows nothing, judged from the scientific standpoint. Dr. Murrell suggests the substitution of Ignatia, a tincture prepared from the Ignatia bean, for the "interminable" nux vomica. As a matter of fact, both tinctures contain strychnine and brucine. The usefulness of ignatia appears to be as wide as that of the corresponding tincture of nux vomica, while it apparently exerts a special controlling influence in hysterical cases. Then, again, as regards bitters, medical men are for the most part conservative and content to ring the changes upon quassia, gentian, and calumba, to the neglect of chiretta, canella, cusparia and other good drugs of that kind. In purgatives Dr. Murrell points out that turpeth may be advantageously substituted for jalap. The points thus demonstrated deserve careful consideration. The British Pharmacopœia is an excellent compilation, but in its present form there is a great mass of overlapping and superfluous drugs and preparations that might be considerably reduced with great gain to its practical value. A concise description of the drugs in common use, with an official indication of the leading groups, such as astringents, heart tonics, alteratives, purgatives, and so on, would furnish a handbook likely to appeal to the practitioner far more than the voluminous book of reference which he now finds at his elbow. We fear, however, that medical educationalists are not yet prepared to simplify and reduce their curriculum. Possibly their knowledge of detailed facts is not yet of sufficient magnitude to warrant such a selection, but nine out of ten general practitioners perform the process of condensation on their own account.

Notes on Current Topics.

Rectified Spirit for Poor-law Patients.

A grotesque incident reported in the *Liverpool Daily Courier* a few weeks ago reveals a depth of ignorant bumbledom that would require the pen of a Dickens to do justice to. It appears that the medical officer of Tarleton ordered a pint of whisky for a patient afflicted with cancer. In the later stages of that terrible malady the prescription was so right and proper that it would hardly have been called in question by the most rabid total abstainer. The matter came before the Ormskirk guardians, who after mature consideration adopted the advice tendered by the Southport Relief Committee that where patients needed alcohol it should be administered in the form of rectified spirit and not of whisky. A champion was found to defend the position in the person of the Rev. Dr. Porter. He produced a sample of the spirit and suggested to the astonished medical officer that alcohol being prescribed as a medicine and not as a beverage, its precise form was not of vital importance. That plea would excuse all vendors of adulterated spirits, many of whom make up enormous quantities of gin, brandy, whisky, and so on upon a basis of methylated and rectified spirits. Recent trials have shown that such persons can be successfully prosecuted by the Excise. That being the case, an action would stand against any person administering rectified spirits in place of whisky. It need hardly be added that from a medical point of view the use of rectified spirits as a drink is absolutely indefensible and criminally dangerous.

Ordinance Against Noise.

Many of our readers who have the misfortune to be light sleepers and to live in the vicinity of churches or railways will envy the happy dwellers in Mount Vernon, U.S.A., where the following edict has just been promulgated by the Board of Health :—"The ringing of church bells, or any other bells, the moving or shunting of trains. except in connection with the through traffic of the railroads, the handling or movement of large masses of rock, metals and other substances, so as to interrupt or disturb the sleep of the residents, will be prohibited in the city of Mount Vernon between the hours of ten o'clock in the evening and six o'clock in the morning. The maintenance of lowing animals, crowing cocks, barking dogs, and other birds or other animals, which produce or are calculated to create noise, to disturb the sleep and quiet of the neighbours, within the same hours, is hereby prohibited." Breach of these stringent regulations is punishable by arrest or a fine of ten to twenty pounds. We notice that the President of this very active Board of Health is a medical man, Dr. Archibald McCampbell.

Want of Organisation in Hospitals.

From a correspondence that has been going on for some time past in some of the leading London newspapers, it seems evident that the outpatient arrangements at many hospitals are by no means perfect. As a matter of fact complaints of neglect or carelessness are never absent from the public press for any great length of time. In some instances the charge is unfounded; in others, it is due to defective judgment on the part of a house surgeon or a nurse, while in others, again, the error is clearly and unmistakably the outcome of want of businesslike method and organisation. One correspondent said that his brother went to one of the largest of our London hospitals, where he was told to go into a side room and strip, which he did. After waiting for three-quarters of an hour without any medical man appearing, he dressed and went home, where he died shortly afterwards. At the inquest it was stated that no record could be found of the visit of deceased at the hospital, and that the resident on duty at the time was away in the country. A matter of this public importance, however, should not be allowed to rest here. Another gentleman, who gives his name and address, states that one of his employés was thrown from a cycle and injured by an omnibus. He was taken by the police to a hospital which shall be nameless. After waiting for some time he was examined by a doctor. That was about nine o'clock in the morning, and he was told that he could not obtain any liniment or medicine until the dispensary was open at 10.30. The fact of the matter appears to be that the resources of the out-patient and casualty staff are hopelessly swamped by the indiscriminate abuse of hospital charity by persons who should be paying their own medical men.

Medical Education in America.

MEDICAL education is at its best and at its worst in America. Some of the great schools of the States, such as Baltimore and Philadelphia, stand in the first rank of the world, while on the other hand admissions to the Register can be gained with practically no knowledge of scientific medicine and surgery. If, however, we are to trust the editorial opinion of one contemporary, *The Journal of the American Medical Association*, there is in the past few years a tendency toward improvement in the education of the medical student. Students are more and more taking into consideration the standing of the college they think of joining, and paying less attention to questions of fees, of entrance requirements, and of length of term. The State examining boards, too, have in most cases shown a wholesome tendency to raise, however slowly, the standard of knowledge required to gain a licence to practise. It is, we suppose, a sign of the crowding of the profession in the States that the number of students of medicine has shown a decline during the last year or two. During the year ending June 30th last, there were 26,147 persons engaged in the study of medicine throughout the entire country, a number less by two thousand than in the previous years. The graduates during the past twelve months numbered 5,606, being 141 fewer than in the previous period. It is satisfactory that the falling off in the number of students has been confined altogether to the homœopathic and eclectic schools, the attendance at the regular schools showing a slight increase.

The Election of the Direct Representative for Ireland on the General Medical Council.

WE regret to say that an attempt is being made by the lay press to deliberately introduce in Ireland the ever-pervading question of religion and politics into the selection of a direct representative on the General Medical Council. Such an attempt is, we believe, fore-destined to failure, but that it should be made at the present time is obvious to every one who is acquainted with the lamentable extent to which party feeling is carried in Ireland. That it should succeed and that one of the most influential posts in the gift of the profession in Ireland should be bestowed on any other grounds than those of efficiency and suitability is, we hope, impossible. THE MEDICAL PRESS AND CIRCULAR holds no brief for any particular candidate, and much less for any particular party or creed, and therefore we hold ourselves free to offer unbiassed professional advice. We trust that the electors will select as candidates men whose past careers show that they are both able and willing to advance the honour and credit of the medical profession in Ireland, and to boldly maintain professional interests where these are wrongly threatened, and that into this selection no suspicion of either religious or political feeling will be allowed to creep. We also trust that these members of the public who would endeavour to exploit the medical profession for their own private or political interests will be taught with no uncertain voice that the medical profession in Ireland will have none of such things.

Lynching.

IT is curious how little attention has been paid to the crime of lynching from the point of view of the psychologist. It can hardly be doubted that the practice of lynching as observed in the Southern States of America is a manifestation of one of the savage instincts which may slumber unsuspected in a people beneath centuries of civilisation. Viewed in this aspect lynching would hold the same place in the psychopathy of society as does homicidal mania in that of the individual. Dr. James Albert Cutter, who has recently devoted himself to a study of the subject in a scientific spirit, has made clear some points which are in favour of this view, and correct many current opinions. We are accustomed, for instance, to think of lynching as a punishment reserved for one special kind of crime—assault on the female person, but an analysis of the figures shows how little basis has this belief. Of the total number of lynchings of negroes during the past twenty-two years, only one-third have been in retribution for rape. Among the minor crimes for which lives have been taken by mob law are swindling, throwing stones, slapping a child, jilting a girl, refusing to give evidence, giving evidence, and "bad reputation." In parts of the country cattle-stealing and horse-stealing are commonly punished in this way. During the same period no less than sixty-three women have been lynched, of whom one-third were white.

A Standard of Puerperal Morbidity.

Considerable attention has been directed during the past few years to the subject of puerperal fever, and it has come as a painful surprise to many people to find that in spite of all we know of the nature and causes of the diseases so termed, in spite of the labours of Holmes, of Semmelweiss, and of Lister, mortality from puerperal sepsis in private practice shows little if any diminution. It is, however, notoriously difficult to obtain trustworthy statistics on the subject, and the Registrar-General's figures must be taken as putting matters in the most favourable light possible. Mortality figures, however, are by no means the best method of testing success in obstetric practice, since they only show the most extreme cases, and take no note of cases of puerperal infection in which recovery occurs. It would therefore be well to base results on statistics of morbidity, as if that were done every practitioner, whether his cases were few or many, could form a fair estimate of the success of his treatment. The difficulty, however, is to agree on a standard of morbidity, and up to the present every obstetrician has been a law unto himself in this matter. We are glad to see that as a result of a paper read before the British Medical Association in July by the Master of the Rotunda Hospital, Dr. Hastings Tweedy, steps are to be taken to appoint a representative committee who should endeavour to fix on a conventional standard of morbidity to be used at anyrate in the maternity hospitals throughout the kingdom.

A Miracle and a Dog.

It would be difficult to find anyone so exuberantly naif as the latter-day newsmonger. He never learns by experience, he is always surprised at the same things, however frequently they happen; and he is always unearthing new things as old as the hills. It is a great gift, this perpetual youthfulness of the mind, but some newspaper readers grow old and wish to put away childish things, and then they get a little tired of the old favourites. During the last few days two startling phenomena have been reported. The first is a real live miracle—needless to say from Wales. The subject was a woman, twenty-four years old, who, for five weeks had lain in bed suffering "considerable" pain from tuberculous disease of the hip. She knew it was tuberculous disease of the hip because the doctor had said so, but physical signs seem to have been conspicuous by their absence. Well, this wonderful story goes on to say that the girl's pastor and a neighbouring colleague came to pray with her, and to the astonishment of all the girl announced that she was going to get up. "Without any assistance she rose, dressed, and went downstairs." The doctor's surgery was visited ,and Rhoda was not more aghast when Peter appeared, than was the doctor when he saw her. A conversation anent the comparative merits of heavenly and earthly healers then ensued, but into this we need not enter. The other story is the old "wheeze" of the hospital dog. We all know that dog. He gets hurt in the street and is taken to the hospital. There a kind-hearted student dresses him, and he comes every day after that for his dressing to be changed. The last phase—which the present dog hasn't reached—is for him to bring his canine friends to the hospital with him when they get hurt. Is it not all written in the Sunday school books? And so the world gets older, but the journalist does not.

Hospital Openings.

We notice in the announcements of the opening of the year's work at the various hospitals that a change is coming o'er the spirit of the dream. The old-time inaugural ceremony contained as its *piece de resistance* an oration wrung unwillingly from first one and then another member of the hospital staff—an oration which was listened to with respect and followed by a sigh of relief, in which latter no one joined more heartily than the unfortunate orator who had been impaled on the stake of custom. Of late years there has been a tendency to prevail on a distinguished outsider to give the introductory address, and certainly a fresher atmosphere has often been created by so doing. But the process is becoming threadbare, and this year five of the London schools and six of the provincial ones will forego the usual streams of platitudes, heroics, and complaints that have annually prepared the soul of the new student for the beginning of his life's work. Some sort of annual gathering is to be commended, and the hospital dinners will continue to flourish in spite of the decay of home oratory. There are no pleasanter functions in the year than these assemblies when old comrades and friends from all parts of the globe meet to discuss their fortunes since the last dinner, and it is not surprising to note that every hospital in the metropolis is arranging for one this October. The post-prandial speeches may not be so eloquent, but they are certainly more spontaneous than the afternoon's performances.

Salvation by Sea-Water.

The Borough of Poplar is groaning under a heavy burden of rates, not an inappreciable proportion of which seem to be expended on free disinfectants. We have never had much sympathy with the policy of scattering disinfectants far and wide, as they are probably used to cover up sanitary defects which should be remedied by the plumber and not palliated by carbolic. But disinfectants seem in demand at Poplar, and the medical officer of health, Dr. Alexander, has just presented a report to his authority under the title of "Sanitation by Electricity," in which he advocates the installation of electrical plant to convert sea-water into a disinfecting fluid. So daring a scheme has naturally found its way "into the papers," and the merits of this great idea are being freely set forth in the daily press. The principle of electrolysing sea-water, and thereby converting the chlorides of magnesium into hypochlorites, has long been known, and the experiments made at Worthing many years ago showed the resulting liquid to have some value as a deodorant and oxidiser, and to be considerably freer from organisms than water not so treated, but it is a far cry to assume that the electrolysed sea-water is a disinfectant of any particular value. It is certainly easily reduced and rendered inert by contact with organic matters, and that alone is a great drawback to any disinfectant. Probably the Poplar Council will think twice before they set up the plant suggested, and perhaps may find in sea-water as rapid a way out of their troubles as Lord Palmerston suggested in the case of Ireland.

Health of Glamorgan.

IT certainly is high time that the County Council of Glamorganshire stirred up the district sanitary authorities in their area, for the 1904 report of their Medical Officer of Health discloses a state of things which it is difficult to characterise in parliamentary language. During the year 192 samples of water supplied in the county were analysed chemically, and of these 138 were satisfactory, 47 suspicious, and seven bad; 235 samples were examined bacteriologically with the result that only 115 were satisfactory, 106 were suspicious, and 14 bad. None of the district councils possessed a laboratory and none of them employed their medical officers to undertake analytical work. One need not feel surprise then on turning to the vital statistics for the year to find that like so many of the samples of the water, they are "unsatisfactory." The death-rate from the seven principal zymotic diseases was 2·29 against 1·91 for England and Wales, and the general death-rate from all causes was 0·35 higher than the general death-rate of the two countries. The rate of infantile mortality was 176 per 1,000 births as against 146 for England and Wales, and most of the epidemic diseases seem to have been rife. Thirteen out of a total of thirty sanitary districts discharge crude sewage into rivers or the sea, and one local council tipped its house refuse into the bed of a river. The County Council is now aware of what is going on, and with the aid of its medical officer, seems prepared to tackle the backward and careless authorities under its jurisdiction.

The Curability of Epilepsy.

IN some disorders symptoms may be successfully repressed for comparatively long periods of time by appropriate remedies, but as soon as these are discontinued they break forth again with renewed vigour. Epilepsy is one of these. To the neurologist it is an affection of considerable interest, assuming, as it does, so many different forms, but to the practical physician it is more often a source of disappointment than otherwise. The practitioner is advised to "follow the fit about" with medicines suited to the particular phase of the complaint which happens to predominate. This is done sometimes with excellent results, and both parties are buoyed up with hopes of really permanent cure. The treatment is, nevertheless, persistently carried out, it may be for some months or even years, during which time the disease seems to have disappeared. One day the patient takes the law into his own hands, and, feeling perfectly well, omits his medicine altogether. Retribution is swift; the fits return without any warning and with redoubled energy. This is by no means a hypothetical case, such an instance being related at a recent meeting of the West London Medico-Chirurgical Society. The subject is also ably discussed by Dr. James W. Wherry, in *Journ. Nerv. and Ment. Dis.* (May, 1905), who is of the opinion that an acknowledgment on the part of the profession of its inability to cure epilepsy opens the door at once to quackery. Advertisements may be seen in most of the newspapers of such nostrums professing to cure fits of all descriptions. That epilepsy can actually be cured is shown by the statements of such authorities as Nothnagel, Turner, Spratling, and others. If a case of epilepsy remains absolutely free from fits for anything over three years without treatment at all, it may fairly claim to be called cured. The importance of individual care and treatment is rightly insisted upon, this being the only road to success.

School Babies.

FOR once a strong, clear, level-headed report has found its way from the Education Board on a question about which medical opinion has long been focussed. We mean the "instruction" of babies in schools. It is difficult to see how any person acquainted even slightly with children could have supposed that any good, physical or mental, could accrue from herding mites of from three to five years of age in school-buildings for so many hours a day, and setting a "certificated" mistress to impart knowledge to them. But such has been the system all over the country, and some £800,000 a year has been spent on it. Sir William Anson recently showed what his opinion in the matter was by the circular he addressed to education authorities giving them the option of discontinuing this absurd work, and now the Board has published the report of Mr. Cyril Jackson, chief inspector of elementary schools, and of five women colleagues specially detailed for the work of investigation into infant schools, in which the system is unsparingly condemned. "There is," writes Mr. Jackson, "complete unanimity that the children between the ages of three and five get practically no intellectual advantage from school instruction." These are common-sense words, and medical men would be inclined to add that such children probably get a good deal of harm. Between three and five children need plenty of sleep, plenty of food, and plenty of play, and as the report points out, those children who do not begin schooling till they have past this age, rapidly pick up what the others have been labouring at for two years. To those who wish to substitute some form of kindergarten instruction for the babies, it may be pointed out that medical officers of health have shown over and over again that infant schools are hot-beds of all the infectious diseases to which children are subject.

The Medical Profession in Politics.

The recent action of certain medical men of Hampstead in ascertaining the views of the rival candidates at the next parliamentary election opens up a new departure of wide and far-reaching importance. The questioners were members of the local branch of the British Medical Association. Now, however desirable it may be for the profession to bring its influence to bear upon members of Parliament with a view to medical reforms, it is highly questionable whether such pressure can be applied through an agency like the B.M.A. Who is to settle the unanimous policy of the Association in the first place? Is the branch to be tied by the policy of the central body, and are its members pledged to vote for Radical or for Conservative according to the views of party candidates as to measures of medical reform ? Until these elementary points are settled it seems a waste of energy to pester candidates. Obviously a Radical, say, in the north of England might answer favourably, while a Conservative in Cornwall might be unfriendly. Then the Yorkshire branch, if it voted for the Radical, would neutralise the Cornwall branch. Besides, how can a branch, composed as it is of men of every shade of political opinion, come into the field as a great fighting force ? The history of the failure of small bodies of men to advance some particular belief by influencing electors is all around us. Take the case of the temperance party and the antivaccinationists. Here and there they upset an election, but they have absolutely failed to get any real hold of Parliament. If the medical profession is to make its influence felt in the world of politics, it will be by the enlightened public action of individual members rather than of associations.

An Old Temperance Fallacy.

The utterances of temperance advocates are not, as a rule, characterised either by foreknowledge or by scientific truthfulness. To the average writer or speaker from that platform any stick is good enough to beat intemperance with. One of their common errors is to assert that the child of alcoholic parents comes into the world saturated with alcohol, and is therefore hopelessly handicapped in the battle of life. As a matter of fact, many children born under such circumstances grow up into sane, capable and temperate citizens. The fallacy appears to be world-wide. Recently an American sent a letter of portentous length to the *Daily Telegraph*, airing his views as to the past, present and future of our Army and Navy. Britishers he regards as hopeless degenerates, and in the course of his jeremiad occurs the following passage :—" Furthermore, the American women do not drink alcohol one-tenth of the extent Englishwomen do, and therefore American children are not saturated with alcohol as English infants are. The plain truth is, the English are suffering from the physical diseases which arise from excess and immorality." Notwithstanding this sweeping assertion, we venture to think that the British will compare favourably with the American as regards national physique. The supremacy of many northern nations that have been notoriously addicted to drink must be considered if we are asked to consider alcoholism in the parents as a direct cause of degeneracy in the offspring. Without wishing for a moment to minimise the evils of strong drink, we think it would be wiser not to advance assertions that are founded upon pure assumption until they become a kind of gospel to the temperance advocate. Truth is truth.

The Metropolitan Asylums Board Medical Service.

For a long time past the conditions of the Metropolitan Asylums Board Medical Service have been the cause of a great deal of dissatisfaction. Matters were brought to a head some short while ago by the resignation of three of the medical officers at Darenth Asylum by way of protest. A circular letter was sent by the resigning officials to their brother officers in the same service. There is a general feeling that no one should apply for the vacant posts until the promised investigation has been made by the Asylums Board. One of the many causes of friction has arisen from the fact that the medical officers rank as subordinates, while the matron, the steward, and even the clergyman and the schoolmistress, rank as their superiors. To have divided authority in a great medical establishment is to court inefficiency, wrangling and disaster. An absolutely similar thing occurs in various large Poor-law infirmaries, and were it not for the usually short term of office of the medical officers serious disputes would often come to light, whereas now little or nothing is heard about them. In the Asylums Board service, however, the medical officer takes up his office as a permanency, so that the question of his authority becomes a matter of vital importance to his comfort not less than to his efficiency. Another point is that the salaries are inadequate, so that a medical officer, after fifteen years' service, receives only the pay which a lieutenant of the Royal Army Medical Corps obtains when just commissioned. It is to be hoped that the result of the inquiry will be to remedy these undoubted grievances, and that until they are remedied that no other medical men will apply for the posts.

PERSONAL

Dr. John Cameron, B.Sc., has been awarded a Biological Research Fellowship for the third year in succession by the Carnegie Trustees.

Lieutenant-Colonel A. M. Davies has been appointed Professor of Hygiene at the Royal Army

Medical College, *vice* Lieutenant-Colonel R. H. Firth, who has completed five years' service.

DR. HARRY CAMPBELL will deliver the Introductory Address to the Winter Course of Post Graduate Lectures and Demonstrations, given at the Central Out-Patient Department, 7, Fitzroy Square, of the Mount Vernon Hospital, on Thursday, October 12th, at 5 p.m. Subject, "The Enlargement of the Chest in Pulmonary Disease." Medical practitioners are invited.

LADY LUMSDEN, widow of the late Sir Harry Lumsden, has made the very generous offer of £1,000 for the purpose of starting an Aberdeen Sanatorium for Consumptives, on condition that, if nothing should be done within the next six months towards building such a Sanatorium, the offer would be withdrawn.

DR. S. R. HAWORTH has been appointed District Surgeon at Van Rhynsdorp, Cape Colony, in succession to Dr. G. W. Young, who has resigned.

Dr. J. SALMON SMITH has been appointed a Medical Officer of the Colony of Lagos.

ARRANGEMENTS have been made by members of the profession in Birmingham and the surrounding districts to entertain Sir Thomas Chavasse at a dinner to be held at the Grand Hotel, Birmingham, on Thursday, October 5th. We are asked to state that if any medical practitioner in the neighbourhood has been overlooked in sending out the circulars, he can obtain a ticket by applying to Dr. Thomas Nelson, 70, Hagley Road, Edgbaston..

ON Tuesday afternoon the Right Hon G. W. Balfour delivered a short address to the students at the opening of the Winter Session of the Medical School of the Leeds University, and Lady Betty Balfour distributed the prizes to those successful in the competitions during the past year.

PROFESSOR C. J. FUCHS, of the University of Freiburg, and Dr. Mewes, of Düsseldorf, have lately paid a visit to Liverpool for the purpose of studying the housing question as dealt with in that town.

Special Correspondence

[FROM OUR OWN CORRESPONDENT.]

BELFAST.

QUEEN'S COLLEGE, BELFAST.—The topic of most interest at the present moment is Sir Donald Currie's munificent offer to the College, and the chances of the full amount needed being raised. The gist of the offer is that he will give £20,000 to the College provided a similar sum is raised before Christmas, or £10,000 if that sum should be raised and the larger amount not reached, or if not even the smaller amount is collected he will give a sum proportionate to what is collected. The first list of subscriptions will appear in a few days, but meantime it is said that the £10,000 is within sight, and great hopes are entertained that the full amount will be raised. As the College Equipment Fund has raised about £30,000 in the last five years, this means that about £70,000 would be available for the better equipment of the schools. There is no doubt that the medical school will benefit very largely.

The President's report for the year 1904–5 has just appeared, and shows that the number of students is increasing in all departments, the entry last session being the largest for thirteen years. The number of students regularly entered on the roll was 395, while 106 more attended various special courses of lectures.

Referring to changes in the staff during the year, the President speaks of the loss sustained by the death of Dr. McKeown, who was lecturer on Ophthalmology, and the appointment in his place of Dr. Cecil Shaw, and he points out that the election of Dr. Shaw is the fourteenth appointment of an alumnus of the College to a position on the staff during the sixteen years in which he (Dr. Hamilton) has held the Presidency, while during the previous forty years the number of Queen's College men so appointed was five.

PUBLIC HEALTH.—At a recent meeting of the Public Health Committee an extract from Dr. Clibborn's report to the Local Government Board was laid before the members, and it is satisfactory to find that the Board's Inspector finds some marked improvements in the city. The chief of these, perhaps, is the abolition of the old and objectionable privy and midden system, and the substitution of water closets. In the year 1897 there were no less than 26,620 such privies, and now this number has been reduced to less than 6,000. In some portions of the city it is necessary to relay the drains before water closets can be introduced, hence the delay in effecting the total abolition of the old system. The Inspector also remarks: "I notice a marked improvement in the condition of the dwellings of the poorer classes, owing to the periodical visits of the female inspectors, which have an educating influence in the matter of cleanliness and ventilation."

Correspondence.

MONOTONY IN PRESCRIBING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Some years ago an analysis was published of over 25,000 prescriptions, from which it appeared that tincture of nux vomica was ordered more frequently than any other drug or preparation. Nux vomica is undoubtedly a very valuable drug, but it is an open question whether other members of the same natural order, the Loganiaceæ are not equally useful. Fashion to a very great extent is responsible for the medicines we use. Nux vomica is universally popular; ignatia is ignored. This very popularity brings the art of therapeutics into disrepute. The patient who finds nux vomica in every prescription, quite irrespective of the nature of the ailment from which he may be suffering, is apt to lose faith in the originality of orthodox members of the profession, and to drift into the hands of quacks. There is no reason why instead of the interminable nux vomica we should not sometimes use ignatia. Both contain strychnine and brucine. With regard to cost, I find on consulting the only price list at my disposal, that tincture of ignatia costs a few pence a pound more than tincture of nux vomica, but the difference is so slight as not to be worth taking into consideration. I am not sure, though, that the advantage in this respect is not in favour of the ignatia, for the dose of the tincture is from two to five minims; whilst that of tincture of nux vomica is from five to fifteen minims. The strength of the tincture of ignatia is one in ten; the tincture of nux vomica is made from the liquid extract, and its strength is estimated in terms not of the crude drug, but of strychnine. It is said that ignatia varies somewhat in the amount of alkaloids it contains, but if the tincture came into anything like general use there is no reason why it should not be standardised.

Ignatia in most prescriptions can well be substituted for nux vomica. It has a wide range of usefulness, and is "indicated" in many forms of departure from the normal conditions of health. It is in no way incompatible with other drugs commonly prescribed, and is not more likely to give rise to disagreeable or toxic symptoms than nux vomica. It is a stomachic stimulant and may be given with any of the ordinary bitters such as gentian, quassia, or calumba. It relieves flatulence, and by stimulating the peristaltic action of the intestines acts as a mild but efficient laxative. In sick headache it relieves the pain and sense of depression promptly. It acts on the respiratory centre and is useful in emphysema and chronic bronchitis attended with dyspnœa. It is a cardiac stimulant and is especially useful in dilated heart. In peripheral neuritis and in many forms of progressive muscular atrophy it tends to prevent further wasting of the muscles. In alcoholism it does much to ward off the craving for stimulants. Its sphere of action is a wide one and there is no reason why it should be so systematically ignored. In most works on therapeutics it is dismissed with the curt remark that its action is the same as that of nux vomica. I am not so sure that this is the case, and I am inclined to think that ignatia has a sphere of usefulness entirely its own. Certainly in many forms of hysteria, using the word in its widest sense, it exerts a beneficial and controlling action when nux vomica fails. In these cases it is best given in small doses. A useful prescription is half a drachm of the one in ten tincture in four ounces of water, a teaspoonful every quarter of an hour and then hourly for six hours. It may be argued that as nux vomica and ignatia both contain strychnine and brucine their action must be identical, but clinical experience fails to bear out thiscontention. It may be that the alkaloids are in a slightly different form of chemical construction. We know well that by altering in ever so slight a degree the chemical composition of an active principle we materially modify its pharmacological action. Ignatia quite apart from its obvious therapeutical uses seems to have properties peculiar to itself and distinct from those of nux vomica. In many points they overlap, but in others there is a divergence. It is only by extensive clinical use and careful observation that minute differences in action and value can be differentiated.

The principle of selection might be still further extended. Take the group of the bitter tonics, for example. Some people always use gentian, others always quassia, and others again invariably calumba. Even here a little variety might be welcome and it would be easy to ring the changes not only on gentian, quassia, and calumba, but on chiretta, cannella, cusparia and other members of the group. Most of us weary of the name of jalap and of hearing complaints of its unsatisfactory action, and yet few of us think of using turpeth. Turpethum is actually official, and finds a place in that little known work the Indian and Colonial Addendum to the British Pharmacopœia. It is the dried root and stem of ipomœa turpethum, and given in powder in half-drachm doses is an efficient and drastic purgative. For nearly three years I have used it in hospital practice and find it more trustworthy and constant in its effects than compound jalap powder. It is true that of late it has been to some extent superseded by the synthetical purgatives such as phenol-thalein. Again in the treatment of the night-sweating of phthisis atropine is almost universally prescribed to the exclusion of picrotoxin, which in doses of 1-60th of a grain in pill at bedtime rarely fails to afford relief. Permanganate of potassium and binoxide of manganese are popular remedies for functional amenorrhœa, but senecio, in spite of numerous papers which have been published on its action and uses has never found its way into general use, partly perhaps from the fact that it is a common plant which flowers in every field and by the hedgeside. The "addendum" is full of good and useful remedies, but in this country no one thinks of giving them a trial or seems conversant even with their names.

There is no necessity for discarding old and well-established remedies, but there would be no harm in adding to their number; and ignatia as an alternative for nux vomica may well receive attention.

I am, Sir, yours truly,
William Murrell.

Welbeck Street, London, W.,
October 1st, 1905.

THE LONDON TEMPERANCE HOSPITAL AND TEMPERANCE STATISTICS.

To the Editor of The Medical Press and Circular.

Sir,—In a report furnished by Dr. Robert Burns, Hon. Secretary of the London Temperance Hospital, statistics are formulated, or I should rather say presented, which purport to compare the more favourable mortality of the temperance with general hospitals. As I feel confident in my own mind that there is a fallacy in these reckonings, may I illustrate my meaning? The report in question narrates that whereas the admissions in the general hospitals were 65,656 with a death-rate of 9·1 per cent., those in the Temperance Hospital were 1,337, with a death-rate of only 7·3 per cent. Now, Sir, it seems fairly obvious that the great majority who seek refuge in a temperance hospital would either be total abstainers, or extremely abstemious people; at any rate, I venture to predict that if any given number of persons had the choice of a hospital, the vast majority of the intemperate would reject the Temperance Hospital.

Having arrived, therefore, at this fact, if it be a fact, we can infer with reasonable certainty that the Temperance Hospital would escape for the most part those organic diseases and the pathological conditions, and degenerative changes in the system due to alcohol. Not only so, but they would also escape the secondary consequences of intemperance, debauchery, venereal disease, and other forms of dissipation often the result of drink. In one word, the patients of the Temperance Hospital would drift from a purer school than those which fall to the lot of the general hospitals. Further, it so happens that the Temperance Hospital has a certain proviso where stimulants are admissible in "exceptional cases," of which they keep a record.

The only evidence, therefore, I submit which the Temperance Hospital can produce with regard to the effect of alcohol on mortality is—(1) That a large number of cases—indeed, the great majority—will recover from disease without alcohol. (2) That in the "exceptional cases" treated with alcohol, some of which may recover, and some of which may die, there is no evidence whatever to show the effect the alcohol might have had on their mortality.

In order to convince the world of the benefits of non-alcoholic treatment, the Temperance Hospital, I submit, must either attach a wing to their hospital for *patients under alcoholic treatment*, giving the public the choice which to select and then compare, or they must relegate this experiment to the general hospitals, which latter, I gather from the report, has been suggested, but the general hospitals have very wisely refused to undertake the responsibility of the experiment.

This question being one of such vital importance to the general community, may I be permitted to inquire on what is the basis of assumption founded, that the Temperance Hospital claim to treat disease better without than with alcohol?

I am, Sir, yours truly,
Clement H. Sers.

Brighton, Oct. 1st, 1905.

LONDON'S WATER SUPPLY.

To the Editor of The Medical Press and Circular.

Sir,—Attention has lately been directed in your own and other influential journals to the London water-supply and the pollution of the Thames—the chief source of drinking-water for the Metropolis—with waste oil from the pumping stations of the Water Board. This is sufficiently objectionable, but a much more serious contamination exists in the organic matter, animal and vegetable, in suspension and solution. It cannot be too strongly urged that this menace to public health cannot be got rid of by the construction of new reservoirs and filters, as proposed by the Metropolitan Water Board. In his valuable recently-published report on this important subject, Dr. W. Scott Tebb, M.A., D.P.H., public analyst to the Borough of Southwark, refers to the evidence of Dr. Ashby before the Royal Commission on the Metropolitan Water Supply in 1903. During his inspection of the state of the river below Oxford, Dr. Ashby called attention to the following sources of pollution:—(1) Many farmsteads drained into the stream, presenting innumerable opportunities for pollution by cattle, and washings from manured land, &c. (2) Parts adjacent to canals communicating with the river were often manured with house and other foul refuse from London. "I have seen," says Dr. Ashby, "large deposits of such refuse fouling the streams." (3) Decomposing animals. (4) Filthy bilge water from barges carrying offensive cargoes. (5) Pollution from floating population of canal boats, houseboats, &c. (6) Pollution from laundries, tanneries, fellmongers' yards, breweries, and paper mills. (7) Direct sewage and slop pollution from towns and villages. (8) Effluents from sewage works. With regard to the so-called purification of sewage, Dr. Ashby was of opinion that to assume that because the sewage of a place was cut off from the rivers, and treated by some chemical process or land irrigation, therefore there was no pollution, was quite a mistake. Notwithstanding that the sewage of Oxford, Uxbridge, and Watford is so treated, he (Dr. Ashby) "found much pollution by excessively foul effluents from those places." Dr. Ashby sums up as follows:—"Having regard to all the facts I have ascertained, and bearing in mind the various chances of pollution which cannot be avoided, however carefully the sewage of inhabited places may be excluded, I cannot but regard the river Thames as an undesirable and unsafe source for the water-supply of London."

In view of the overwhelming evidence as to the unavoidable and irremediable pollution of the present London water-supply, Dr. Tebb maintains that to continue to derive water for domestic purposes from such a tainted source is to ignore the evidence of all trustworthy experience, and courting disaster. A new and pure supply of water must be had at all costs, and the sooner the Metropolitan Water Board recognises this fact the better, both in the interests of the public health and true economy. It is not likely that Londoners will be "content to drink diluted sewage," and already a suggestion has been made to found a Society with the object of obtaining a pure and satisfactory water-supply.—

I am, Sir, yours truly,
HYGIENE.

September 28th, 1905.

VENESECTION IN PNEUMONIA.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I was much interested in Dr. Alexander Morison's communication on the treatment of some phases of pneumonia, and his plea for bolder treatment by venesection, but to me it was also somewhat ancient history. May I refer to the Gulstonian lectures of Dr. W. O. Markham published in 1864 on "Bleeding and Change of Type of Diseases," and his remarks on venesection to relieve cardiac oppression and obstruction in inflammatory conditions of the lungs, to illustrate two points:—

(1) To show how long it takes for ideas on treatment, when opposed to fashion in treatment, to get a footing.

(2) To illustrate the value of some of our old literature.

Dr. Markham asserted "that the rigorous exclusion of blood-letting is founded on error and is a misfortune to suffering humanity."

This is his thesis, which he develops fully, whilst he deals at the same time with the supposed change of type in diseases advocated by Dr. Stokes and other eminent practitioners of the day.

Markham's lectures have influenced my own practice, and I see no reason now to change my views. I have adhered on his lines to three methods which have gone out:—(*a*) leeching; (*b*) cupping; (*c*) venesection; but I have followed the principles so logically enunciated by him.

I cannot encroach on your space by quoting pages from Dr. Markham's pamphlet, which can be consulted, I have no doubt, at any of our medical libraries—even in 1905—it is worth reading.

Whilst writing I am reminded of another book which has also materially helped me, as it enabled me in 1866 and since to ease the minds of many patients suffering from albuminuria, a symptom which in 1866 was regarded as of the gravest moment and was an insuperable bar to insurance. The title of the book is—"Traite des Maladies a Urines Albumineuses et Sucrees," pp. 732. Par Docteur J. Abeille. Paris: Bailliere et fils. 1865. He clearly defined albumin "*passagere*" and "*albuminurie persistante*" with illustrative cases. I have read since then many original communications on the presence of albumen, on its discovery by various tests, and its passing nature, but reading these modern views I have always thought of how old Abeille had forestalled many of them, and of the value of some of our old literature.

I am, Sir, yours truly,
AN OLD PRACTITIONER.

September 27th, 1905.

Obituary.

THOMAS BELL GRAHAM, M.B., C.M., ABERDEEN, of Bradford.

WE regret to announce the death of Dr. Thomas Bell Graham, of Frizinghall, at the early age of 42. It was not generally known that Dr. Graham was dangerously ill, and in fact he had been laid aside less than a week. The case, however, was one of severe blood poisoning, arising from a slight scratch on the finger, which gradually involved the whole of the arm, and proved fatal.

Dr. Graham, came from Ecclefechan, in Dumfries. He was educated at Aberdeen University, where he took the degrees of M.B. and Ch.B. in 1884, the year in which he attained his majority.

A man of very genial disposition and much natural aptitude, Dr. Graham had enjoyed considerable popularity, and among medical men his abilities always received ready recognition.

Literature.

JELLETT ON MIDWIFERY. (*a*)

DR. HENRY JELLETT is so well known to a wide circle of past and present Dublin students as an able teacher and to a much wider circle as a literary exponent of obstetrical and gynæcological knowledge, that the present volume bears on its very title-page a compelling claim to consideration. It has an additional claim in the fact that the Dublin lying-in institutions can boast of a prestige and an authority which are second to none in the British Isles, and that it is many years since the views of the Dublin School have been expressed in a large and complete volume on Obstetrics.

The book consists of ten parts, with sub-divisions into chapters. Part I. deals with Obstetrical Anatomy, Maternal and Ovular, and we gather that the four chapters composing it are from the pen of Dr. T. G. Moorhead. The subject is treated fully, yet not too minutely, and it is not unreasonable to expect the student to master its details, as here presented. The anatomy of the fœtus includes the position of the fœtus in utero, and the facts concerning attitude, position, and presentation are given clearly, and summarised in useful tables. The author includes four terms, namely—attitude, lie, presentation, and position. The term "lie" is an innovation, and is used to express the relation of the long axis of the fœtus to the uterus, as distinguished from "position," which means the relation between some fixed part of the fœtus in utero and the middle line of the mother. The dis-

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(*a*) "A Manual of Midwifery for Students and Practitioners." By Henry Jellett, B.A., M.D., F.R.C.P.I., Gynæcologist and Obstetric Physician to Dr. Steeven's Hospital, Dublin; ex-Assistant Master, Rotunda Hospital, &c.; with the assistance in Special Departments of W. R. Dawson, M.D., F.R.C.P.I., H. C. Drury, M.D., F.R.C.P.I., T. G. Moorhead, M.D., and R. J. Rowlette, M.D. With 9 plates and 467 Illustrations in the text. Pp. xxv. and 1,168. Price 21s. net. London: Bailliere, Tindall and Cox.

tinction is a useful one, but the term " lie " strikes us as inelegant and not particularly happy. The *lie* of the fœtus means, in fact, its *direction*—longitudinal or transverse, and we should have preferred the use of the latter word. Part II. treats of Obstetrical Asepsis and Antisepsis, the Obstetrical Armamentarium and Obstetrical Diagnosis. A very good summary of recent work on the bacteriology of the genital tract is given; recent researches, as the author shows, all tend to the view that the normal vagina during pregnancy is aseptic when no examination has been made; and the practical deduction is that routine douching before labour is unnecessary, and may be harmful. With this teaching we entirely concur. The author lays stress on the value of abdominal examination, and points out that in many cases a vaginal examination is superfluous. In the section on vaginal examination there is a statement which we think must be due to an oversight: " It is generally considered advisable," says the author, " to examine the *left* side of the pelvis with the *right* fingers in the vagina and the left hand on the abdominal wall, and the right side of the pelvis with the hands reversed." (The italics are ours.) Our experience is that for examining the left side of the pelvis, it is very much easier to use the left hand in the vagina, and the right hand on the abdomen. Part III. deals with the Physiology of Pregnancy, Part IV. with the Physiology of Labour, and Part V. with the Physiology of the Puerperium. In these important sections, occupying some 460 pages, it is not to be expected that the author has anything specially new to tell us; but they are written very clearly, and the teaching in the matter of the management of labour and the puerperium is sound, practical and trustworthy. We may note that just as the author discountenanced routine douching before labour, so also he disapproves of the practice after labour. If a douche is given at all within the first four days after labour, he thinks it should be intra-uterine, because with a vaginal douche the current is not strong enough to wash away putrid lochia or retained clots. But in this connection Dr. Jellett perhaps somewhat minimises the value of a hot vaginal douche as a stimulus to uterine contraction. In Part VI. the Pathology of Pregnancy is discussed. This occupies about 250 pages, and is one of the very best sections in the book. It is quite impossible to review it in any detail, but we can promise any one who reads it that he will find it absorbingly interesting and highly instructive.. The author embodies all the latest researches into such important subjects as vesicular mole, chorion-epithelioma and eclampsia: he gives an interesting review of the relation of the zymotic fevers of pregnancy and firmly takes up the position that "puerperal scarlatina" is a misnomer, and that a patient has either scarlatina or septicæmia, but cannot have a hybrid form of the two conditions. We are glad to see this position emphasised, because we feel sure that a very unnecessary confusion has been perpetuated by describing as scarlatina cases that were simply septicæmia with a scarlatiniform rash. Part VII. comprises the Pathology of Labour. There is a very good and complete account of contracted pelvis, and we may notice incidentally an excellent and instructive skiagram of a case of Nægeli's pelvis. The complication of labour by fibromyomata of the uterus and by ovarian tumour is dealt with in a broad, judicial spirit; Dr. Jellett very properly points out that in the case of uterine tumours the treatment must depend on various factors which can perhaps only be estimated at the time. He deduces from statistics that in the case of ovarian tumours, ovariotomy gives by far the best results. The practitioner will find our author a useful and helpful guide in the treatment of post-partum hæmorrhage. We heartily endorse his statement that if the third stage of labour is correctly managed the frequency of post-partum hæmorrhage is reduced to a minimum. The Pathology of the Puerperium is the subject of Part VIII., and includes the important subject of puerperal fever, or, as the author properly prefers to describe it, "The Surgical Fevers of Childbed." We have here a clear exposition of a subject that has often been overweighted by confusion and complication. We are glad to see that the performance of hysterectomy in puerperal septicæmia is not encouraged. The author says it " does not appear to us to be an operation with any future before it." Part IX. treats of Obstetrical Operations, and Part X. of the Infant.

We would willingly have given an even fuller account of this Manual of Obstetrics, had space allowed; because we regard it as an excellent work, which is likely to take a permanent place as the standard British Text Book of Obstetrics; and we heartily congratulate Dr. Jellett on the successful result of a work which must have entailed an enormous amount of research. The literary standard of the book is a very high one, and the numerous illustrations are, on the whole, most attractive and helpful. To one or two of these we might make objection, on the ground that they are somewhat crude and unnecessarily diagrammatic, when contrasted with some of the more beautiful drawings in the work. With this exception we have nothing but praise for this work, which reflects the greatest credit on both author and publishers.

A. E. G.

THE EDINBURGH STEREOSCOPIC ATLAS OF ANATOMY. (*a*)

The application of the principle of stereoscopy to anatomy opens up a new aspect of the study of that important subject. The value of ordinary flat drawings has, of course, long been recognised, but the student has always been warned against any attempt to replace actual work in the dissecting room by the use of illustrations. The great feature of the stereoscopic reproduction of actual dissections is that the student is able to refresh his memory from the convincing reality of a picture in relief. The more thoroughly he has performed his dissections in the first place the more valuable will be his stereoscopic atlas. The first two sections of this admirable work have now been published. Section I. deals with the thorax and central nervous system (brain). The general plan is to take a double or stereoscopic photograph of a dissected specimen. The actual photograph is fixed at the bottom of a card, on the upper part of which is printed a description of the dissection and its chief landmarks, with figures of reference. The work is done in an exhaustive manner. Numerous views are given of the heart and pericardium from various points of view, including *in situ* views of the heart with its chambers opened and other instructive studies in relationships of structure. Dr. David Waterston has been responsible for the choice of plates and of dissections. His task has been admirably performed, as would be expected from a writer in his position and experience as lecturer and demonstrator in the University of Edinburgh. Plate No. 13, Section I., shows the interior of the ventricles from the front *in situ* in the thorax, with lungs removed and a window cut in the front wall. It is a revelation of what can be done with stereoscopic work, and should prove a never-ending delight to the enthusiast in medical anatomy. The value of the Atlas, indeed, extends to surgeons, physicians, and specialists as well as to students. Naturally a work such as this is attended with enormous technical difficulties. It wou'd be impossible, for instance, to secure equality in definition and density of negatives, and in the prints. For all that, the task has been on the whole most excellently performed. Dr. Waterston may be congratulated on having produced a monumental and original work, worthy of the best traditions of the University of which he is a distinguished member. Considering the labour and material involved, the price of the whole work, which is

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(*a*) **"The Edinburgh Stereoscopic Atlas of Anatomy." Edited by David Waterston, M.A., M.D.Edin., Lecturer on Anatomy, Edinburgh University. Edinburgh: T. C. and E. C. Jack. 1905. In five sections. £5 [illegible]s.**

published in five sections at £6 5s. net., must be regarded as extremely moderate. The photographs constituting a section are packed in a box. It would be an advantage were it possible to contrive some means of taking out a particular plate for reference without having to dislodge the whole contents of the box—to say nothing of the saving in wear and tear to the cards.

LES NERFS DU CŒUR. (*a*)

THE innervation of the heart is obviously a wide field that has hitherto been cultivated with moderate success by physiologists, and the publication of a volume of some 250 pages on this subject leads one to hope that all moot points have been cleared up.

But there is a 33-page preface to be devoured first, and this is mainly devoted to a denunciation of bacteriology and its influence on contemporaneous medicine. The author draws his arguments from Metchnikoff's scientifically playful essays on longevity as influenced by the large intestine, and taking these seriously he runs full tilt at the mirage he has himself evoked. We are unable to detect the bearing of the preface on the matter in hand, which, after all, must stand or fall on its own merits.

As far back as 1866 the brothers Cyon described the action of the accelerator nerves of the heart and their name has remained associated with the physiology of this physiologically interesting organ. Since then a vast amount of energy has been devoted to the study of the cardiac function, and in this volume we have an exhaustive description of the complicated mechanism by which the heart's action is accommodated to the variable requirements of the organism. The author lays special stress on the important part played by the central and peripheral nervous systems in regulating the circulation, and he combats *en passant* many "damnable heresies" concerning this interaction.

The most interesting chapter from some points of view is that on the intra-cardiac nervous system, which is described with great elaboration of detail, and is illustrated by numerous observations on the isolated heart, on the influence of temperature and various gases, and on the intra-cardiac apparatus of warm-blooded animals.

Very interesting, too, are the author's observations on the physiological *rôle* of the thyroid gland, the active principle secreted by which, in his opinion, has for function to maintain, and, if necessary, to accentuate the activity of the accelerator and depressor fibres. When in excess iodothyrine determines a morbid hyper-excitability of the heart muscles and gives rise to special symptoms. He points out that iodine, far from being the circulatory depressant described by all text-books on pharmacology, is in reality one of the most powerful agents in determining constriction of the arterioles, and its action is in direct opposition to that of iodothyrine. They both act on the accelerator and depressor fibres, but inversely in point of degree.

Another organ that the author credits with a powerful influence in regulating the circulation of the blood within the cranium is the pituitary body. This organ is peculiarly sensitive to variation in pressure on the part of the cerebro-spinal fluid or blood, and any increase of pressure thereon is immediately followed by slowed heart-beat and a fall of blood-pressure; in other words, the pituitary body is the auto-regulator of inter-cranial blood pressure. The author states, however, that this body produces several active substances, one of which exerts a marked influence on the strength and rapidity of the cardiac contraction and another that acts on the vaso-motor system. Adrenalin is another organic substance that raises the blood pressure and slows the heart; in fact, there is a whole series of organo-products that affect one or other segment of the circulatory apparatus.

What a wonderful organ is the heart, in view of the complexity of its innervation and its susceptibility to so many disturbing influences. The normal regular working of the heart is dependent upon harmony between the manifold antagonistic and modifying influences, the latter being dependent in great measure on the functional activity of distant organs such as the thyroid gland, the pituitary body, and the adrenals. To these must be added extraneous disturbing agents such as alcohol, tobacco, and the product of alimentary fermentation.

The physiology of the heart will require to be in a great measure re-written now that this magisterial treatise has cleared up so many obscure or ill-understood points. Many of the author's rather dogmatic statements and inferences will no doubt be challenged by his fellow-physiologists, but the large body of observed facts that he adduces will serve as a basis for a discussion which shall determine their precise significance.

FOODS AND DIETARIES. (*a*)

DR. BURNET'S "Foods and Dietaries" has reached a fourth edition, and from this fact it is safe to draw the conclusion that it fulfils what we have often seen described as a "felt want." It is refreshing to find a work on this subject in which the author has no fads of his own to air, and we do not know whether to say that Dr. Burnet's advice in general is orthodox or commonplace. Indeed, it is so orthodox that we find it contains nothing that we did not know before, and therefore we are driven to regard it as commonplace. But at least it is sensible, and if we hear little of purin bodies and uric acid we ought to be grateful—after all that we have suffered on the subject—during the last ten years. For a young practitioner who does not know the way to make the ordinary articles of sick-room consumption, or the dishes that are usually recommended for different complaints, this work will supply the necessary information.

LYDSTON'S DISEASES OF SOCIETY. (*b*)

THE increasing humaneness of mankind towards his fellows is to be regarded mainly as the result of increasing knowledge. Former generations, for example, treated lunatics as criminals, but with a better understanding of mental diseases has come the rational treatment of the insane as the diseased and irresponsible charges of the community. So, too, with criminal punishments. It has been recognised that the wholesale barbarities of the lands that impose transportation and capital punishment for trifling offences was an offence against reason and morality. As a result the rigours of criminal law have been reduced to a humaner code, but nevertheless it must be acknowledged that a vast deal remains to be done before we can regard our criminal system with anything like satisfaction. A first step in the direction of reform must clearly be to gain some insight into the pathology of aberrant man in his offences against society. This attempt has constituted the life-long study of Dr. G. F. Lydston, Professor of Criminal Anthropology in the University of Illinois. His book brings together a great mass of facts and of experience. Such chapters as the neuroses in their relation to social diseases, and the chemistry of social diseases contain material of the highest value alike to the medical scientist, the lawyer, and the social reformer. The subjects of sexual vice and crime are handled fearlessly and, on the whole, philosophically. Obviously a book of this kind is meant for a restricted clan of investigators in the special subject of criminal pathology. Many of the illustrations are of interest.

(*a*) "Les Nerfs du Cœur." By Elie de Cyon. Paris: Felix Alcan. 1905.

(*a*) "Foods and Dietaries; A Manual of Chemical Dietetics." By R. D. Burnet, M.D., F.R.C.P., Senior Physician to the Great Northern Central Hospital. Fourth Edition. London: Charles Griffin and Co., Ltd. 1905. Price 4s.

(*b*) "The Diseases of Society." By G. Frank Lydston, M.D. Philadelphia and London: J. R. Lippincott Co., 1905. Price 15s. net.

Medical News.

St. John's Hospital for Diseases of the Skin.—New Out-Patient Department.

The new Out-patient Department of this hospital is now open, and is provided with laboratory, lecture room, electric room, fitted up for Finsen light, X-ray, and high-frequency treatment, and Sabouraud's treatment of Ringworm. The Chesterfield Lectures, founded in 1895 by the Earl of Chesterfield to promote the study of dermatology, in connection with which a Silver Medal is open for competition to those who have attended three-fourths of the lectures, are free to medical practitioners on presenting their cards, and to medical students who desire to attend regularly; and will be resumed in the new building, 49, Leicester Square, to-morrow (Thursday) evening, October 5th, at 6 p.m., when Dr. Morgan Dockrell will give his opening lecture on the "Simplification of Dermatology." After each lecture demonstrations will be given on special cases, followed by clinical instruction up to 8 o'clock on patients presenting themselves in the Out-patient Department. A syllabus of the lectures will be found in our advertisement columns.

The Cholera.

The *London Gazette* states that the Board of Trade have received a telegram dated September 21st, from Rome:—"Sanitary precautions against Adalia withdrawn." Also a telegram from Stettin, dated September 22nd:—"Two further cases of Asiatic cholera were fatal. Several suspected persons under observation. Merchant vessels from Stettin quarantined by the Swedish Government." And a telegram fom Tangier dated September 25th, :—"Board of Health declared Hamburg suspected port as regards vessels which left there prior to September 14th. After that it is considered a clean port."

The official *Staatsanzeiger* announces that from noon of September 27th, up to noon of the 28th, two fresh cases of illness suspected to be cholera and six cases in which the presence of bacilli was established were officially notified in Prussia. The total number of cases of cholera reported up to the present is 256, of which 87 terminated fatally.

Bequests to Medical Charities.

The late Mr. James Thomas East, of South Hackney, who died on August 20th, left £250 to the North-Eastern Hospital for Children, and £100 each to the London Hospital, the City of London Hospital for the Diseases of the Chest, Victoria Park; Guy's Hospital, the City of London Truss Society, and the Tottenham Hospital for the general maintenance of the ward for children known as the Howard Ward. The London Hospital is made residuary legatee of the estate, and in addition to the sum already mentioned will receive between £2,000 and £3,000.

St. Mary's Hospital Medical School.

Award of Entrance Scholarships, September 1905.—*Open Scholarships in Natural Science*:—T. Hare and D. Scurlock divided the value of combined scholarships, £145 and £78 15s.; J. Menzies and A. G. H. Lovell, £52 10s. each.

University Scholarships.—A. Hamilton, Christ College Cambridge, and R. Knowles, Downing College, Cambridge, 60 guineas each.

The Middlesex Hospital.

This hospital, which has been closed for two months for cleaning and repairs, was opened on Monday, the 18th ult., and as the result of the first week's work (Monday to Saturday), 132 patients have been admitted to the wards, and 1,510 out-patients have been treated. The repairs which the age of the building necessitated were very costly, and will be a great tax on the year's income.

Medical Sickness and Accident Society.

The usual monthly meeting of the Medical Sickness, Annuity, and Life Assurance Society was held at 429, Strand, London, W.C., on the 29th ult. In the absence of Dr. de Havilland Hall, the chair was taken by Dr. Rundery James, and there were also present Dr. M. Greenwood, Dr. J. W. Hunt, Dr. F. S. Palmer, Dr W. Knowsley Sibley, Mr. J. F. Colyer, Dr. J. H Dempster, Dr. St. Clair B. Shadwell, Mr. Fredk. Wallace, Mr. F. S. Edwards, and Dr. J. B. Ball. The accounts presented showed that the sickness experience of the society for the current year had been so far normal, although a considerable number of claims had been met arising from accidents. Most of these had been caused by cycling or motor cars, the use of which by medical men is now rapidly increasing. The finances of the society were shown to be in a sound condition, a large addition to the reserves having been made this year. Prospectuses and all particulars of Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

University of Durham.

The following candidates have passed the First Examination for the Degree of Bachelor in Medicine during September.

Elementary Anatomy and Biology, Chemistry and Physics.—Oscar F. D. Airth, Edmund Hudson, M.R.C.S., L.R.C.P., James A. C. Scott.

Chemistry and Physics.—Harriett A. R. Apps, Wilfred Barkes, Cyril C. Beatty, John G. Campbell, B.A., Harold A. Cooper, Ivor Stanley Gabe, Patrick A. Galpin, Cyril Gray, John P. Jackson, Ernest P. Martin, Ruth Nicholson, Thomas A. Peel, Robert Raffle, Harold W. Sykes, George H. Wood.

Elementary Anatomy and Biology.—Francis F. T. Hare, Hamish M. MacGregor, Theresa de Gournay Miller, Lennox M. Stewart, Dorothea M. Tudor.

Third Examination for the Degree of Bachelor in Medicine:—

Pathology, Medical Jurisprudence, and Public Health.—Honours (Second Class): Herbert Max Levinson. Pass List: Harold H. Blake, George E. P. Davis, George R. Ellis, Elizabeth N. Havelock, Herbert F. Joynt, Edward P.H. Joynt, Charles G. Kemp, Jessie M. Murray, Ermest L. Markham, William Rollin, James W. Smith, Leslie H. Walker, George Walker.

Society of Apothecaries of London—September.

The following candidates passed in:—

Surgery:—A. G. C. Findlay, J. H. K. Sykes, R. H. Terry.

Medicine:—M. L. A. Boileau, J. M. Lynch, R. J. S. Verity.

Forensic Medicine:—M. L. A. Boileau, C. G. Grey, T. R. St. Johnston, S. H. Sugden.

The Diploma of the Society was granted to the folowing candidates, entitling them to practise Medicine, Surgery, and Midwifery:—A. G. C. Findlay, T. R. St. Johnston, J. H. K. Sykes, and R. H. Terry.

The Royal University of Ireland.

The Second Examination in Medicine, Autumn, 1905.—The Examiners have recommended that the following candidates be adjudged to have passed the above-mentioned examination:—

Upper Pass.—David S. Clarke, B.A., Michael P. Fitzgerald, Alan Kidd, Kenneth F. Mulligan, John A. Sinton, Thomas Taylor. All the above may present themselves for the further examination for Honours.

Pass.—Charles Alexander, William Browne, Thomas P. Carroll, James K. P. Clarke, Arthur J. W. Compton, B.A., George Deery, Elliot P. Dewar (Galway), Edmund Doherty, James E. English, James Ferguson, B.A., Edward Forbes, Patrick Keelan, John C. Macaulay, William C. McCullough, Thomas C. McGowan, Mathew J. McGrath, Robert A. McLaverty, Frank J. MacMahon, Henry H. MacWilliam, Ulick J. G. Mulligan, Patrick O'Callaghan, John P. J. O'Connor, Patrick C. O'Donnell, Samuel P. Rea, Rupert A. Smith, Alexander L. Stevenson, Gerald J. W. Tierney, Verner Wiley.

Exempt from further Examination in Practical Chemistry.—John Coumhan John B. Crawford, and Peter J. Keogh.

Notices to Correspondents, &c.

☛ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," 'Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

THE LAITY AND MEDICAL MATTERS.

The medical students of Victoria University, Manchester, have a periodical devoted to the interests and work of that Institution. Its editor has recently unearthed a somewhat worn instance of confusion in the lay mind, which arose at an inquest, when a doctor stated that the deceased had died from 'hæmorrhage into the pons varolii," and the following dialogue ensued: A Juror: "I didn't think it was a drowning case." Coroner: "It isn't." The Juror: "What about the pond then?" The Coroner explained that the pons varolii was not a sheet of water, but "an artery leading from the brain"—and the jury seemed satisfied.

Dr. G. (Fife).—The properties of camphor were well known as early as 1070. The regular rhythm can be restored to an irregular beating heart by adding a little camphor to the fluid being passed through it. It should be borne in mind, however, that in camphor we are dealing with a highly powerful and dangerous poison, a fact that is apt to be to some extent lost sight of in this familiar drug.

Urban.—(i.) There is now a test by which within 24 hours it can be known definitely whether a horse has glanders or not. A fatal case of a man infected from a horse occurred recently, the early symptoms so closely resembling rheumatic fever that the patient was treated accordingly. (ii.) The members of the Veterinary College object to the inspection of cows by M.O.H. on the ground that, in consideration of glanders being communicable to man, the officer will soon also intrude into the stable.

Dr. H (St. Ives).—The idea has been seriously taken up, and a Society for the Culture of Musical Therapeutics has been organised in New York under Dr. E. Guernsey.

Australia.—Without the intelligent co-operation of both patient and physician but little benefit will follow the use of abdominal supports. A properly fitted belt, properly worn, is of use in certain cases of nephroptosis with Dietl's crises.

J. R. W. (Upper Edmonton).—In answer to your question, an extensive outbreak of cholera in London in the year 1854, was traced by the late Dr. Lankester, Coroner, to water from a pump in Broad Street, Soho. The disease attacked only those persons who drank the infected water. As many as 400 persons were attacked within a period of five days.

Volunteer Officer (Yorkshire).—We are glad to get your letter on this important subject, and should be pleased if you would send a formal article discussing the whole question. There can be little doubt that the War Office is acting illegally, or at any rate, unjustifiably, in throwing upon volunteer medical officers the extra work involved in examining whole battalions of volunteers as to their physical fitness for foreign service. When that duty is extended to volunteers not in camp we have no doubt, in our own minds that the action is absolutely illegal, although in the case of men in camp there is a loophole through which Mr. Arnold-Forster may creep in undignified and unworthy fashion.

J. D. Wollaston (Bedford).—The X-rays may confirm, or extend, or even furnish a diagnosis in cases of pulmonary tuberculosis. In many so called "early" cases where physical examination can detect slight changes, say, in one apex, the rays may reveal much more extensive disease not only in that region, but also in the unsuspected lung. Some anthorities go so far as to say that both lungs are invariably affected when the disease is so far advanced as to be detectable by physical examination

A. B.—Certainly, you are entitled to more than the ordinary fee if the consultation and treatment exceeded beyond reasonable bounds the time usually allotted to the purpose.

Meetings of the Societies, Lectures, &c.

Wednesday, October 4th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 p.m. Dr. G. H. Savage: Dangerous Delusions.

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—3 p.m. Mr. Bidwell: Intestinal Surgery.

Thursday, October 5th.

Medical Graduates' College and Polyclinic, (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. A. H. Tubby: Surgical Diseases of Children.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—Chesterfield Lectures:—6 p.m. Dr. Morgan Dockrell: Simplication of Dermatology.

Friday, October 6th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. S. Stephenson: Clinique. (Eye.)

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—10 a.m. Dr. Shutter: Anæsthetics. 4.30 p.m. Mr. Bidwell: Intestinal Anastomoses.

Tuesday, October 10th.

Society for study of Inebriety (20 Hanover Square, W.).—8 p.m. Norman Kerr Lecture: By Professor T. D. Crowther, M.D.

Vacancies.

Cornwall County Asylum, Bodmin.—Junior Assistant Medical Officer. Salary commencing at £1 5 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Kent County Asylum, Barming Heath, Maidstone.—Assistant Medical Officer. Salary commencing at £175 per annum, with lodging, attendance coals, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

Somerset Hospital, Cape Town.—Appointment of two Junior Resident Medical Officers. House Physician ond House Surgeon. Salary £150 per annum, with quarters, rations, for the first year, and £200 per annum, with quarters and rations, for the second year, with first-class passage from Southampton to Cape Town. Applications to Davis and Soper, 54 St. Mary Axe, London, E.C. (See Advt.)

Cheshire County Asylum, Macclesfield.—Assistant Medical Officer. Salary £175, rising to £200 per annum, with rooms, board (no alcohol), and washing. Applications to the Medical Superintendent.

Middlesex County Asylum, Napsbury.—Assistant Medical Officer. (Male). Salary £160 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Westminster General Dispensary.—Resident Medical Officer. Salary at the rate of £120 per annum, with rooms, gas, coal, and attendance. Applications to the Secretary, 9 Gerrard Street, Soho, W.

Manchester Royal Infirmary.—Resident Surgical Officer, Salary £150 per annum, with board and residence. Further particulars on application to W. L. Saunder, Esq. (See Advt.)

Rainhill, near Liverpool, County Asylum.—Assistant Medical Officer unmarried. Salary £150 per annum, rising to £250, with apartments, board, and washing. Applications to the Medical Superintendent.

Appointments.

Collum, Rowland W., L.R.C.P.Lond., M.R.C.S.Eng., Anæsthetist to St. Mary's Hospital Paddington.

Crinks, V. A., L.R.C.P.Lond., M.R.C.S., House Surgeon to the Newport and Monmouthshire Hospital.

Davis, Henry, M.R.C.S.Eng., Senior Honorary Anæsthetist to St. Mary's Hospital, Paddington.

De Jong, E. M., M.R.C.S., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Lymm District of the county of Chester.

Evans, Richard David, L.R.C.P.Lond., M.R.C.S.Eng., Medical Officer of Health of the Llandilo Urban District.

Hopkins, C. L., M.B., B.C.Cantab., Medical Superintendent of the York City Asylum.

Births.

Buchanan.—On Sept. 25th, at Harefield, Middlesex, the wife of Major J. B. Buchanan, R.A.M.C., of a daughter.

Murray.—On Sept. 24th, at Apsley, Stockport, the wife of Robert A. Murray, M.D., of a son.

Marriages.

Parrett—Raine.—On Sept. 28th, at the Minister, Beverley, Edward Erratt Parrett, B.A., M.R.C.S., L.R.C.P., of Thorne, Yorkshire, to Martha Annie Thompson Raine, of Molescroft, Beverley, Yorkshire.

Pooley—Lee.—On Sept. 29th, at St. Michael and All Angels, Chiswick, John Milnes Pooley, M.R.C.S., L.R.C.P., of Nettlebed, Oxon second son of the late Rev. Richard Pooley, to Grace Eveline eldest daughter of W. J. Lee, Esq., of Bedford Park.

Deaths.

Adams.—On Sept. 28th, at Rosebank, 8 Brandon Road, Southsea, Henry Adams, M.R.C.P.Edin., L.F.P.S Glas., and L.M.

Vincent.—On Sept. 25th, at Wanstead, Essex, Mary, the wife of Ralph Vincent of Harley Street.

DOCTOR'S SINGLE BROUGHAM, rubber tyred, upholstered in morocco, in good condition.—Apply, Repository, Hill Street, Birmingham.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, OCTOBER 11, 1905. No. 15.

Original Communications.

THE EMPLOYMENT OF CITRATE OF SODIUM IN INFANT FEEDING. (a)

By F. J. POYNTON, M.D., F.R.C.P.Lond.,
Sub-Dean, Faculty of Medicine, Univ. Coll., Lond.; Assistant Physician to Univ. Coll. Hosp. and Hosp. for Sick Children, Great Ormond Street.

DR. POYNTON brought forward in his paper the results of another year's experience of a method of infant feeding in which sodium citrate was added to cow's milk. In his first contribution, which had been published in the *Lancet*, May, 1904, he had pointed out the earlier work of Arthus and Pages, and A. E. Wright, to the latter of whom he was indebted for the suggestion.

The principle of the application of this method was simple, and consisted essentially in adding to cow's milk citrate of sodium in the proportion of one or two grains to the ounce of milk.

If an ounce of milk is taken, and to it is added a minute quantity of hydrochloric acid, sufficient rennet, and to that two grains of citrate of soda, and is then placed in an incubator at body temperature, a fine loose clot will be formed—a clot very different from the firm, tenacious clot that is formed when the citrate of soda is not added.

The explanation of this difference is disputed. The author has been informed by competent chemists that the acid caseinogen combines with the sodium of the sodium citrate to form a sodium caseinogen, which is of lower molecular weight than calcium caseinogen, the usual compound that is formed in milk curdling. The calcium thus combines with the citric acid to form calcium citrate, which was gradually absorbed into the system, being much diluted by the stomach contents.

On the other hand, other chemists had denied the validity of this, and some held that citrate of sodium had no more influence in altering the milk than such salts as sodium bicarbonate. With this conclusion Dr. Poynton did not agree. He had tested in the laboratory sodium bicarbonate, citrate of potash, and salicylate of soda, and had not seen with these such an alteration in the milk clot as he had observed with citrate of soda. He had looked out a simple and eminently practical method of using this milk, and now used it largely in his out-patient department at the hospital for Sick Children, Great Ormond Street.

Citrate of sodium was very soluble in water, to the extent, in fact, of twenty grains to the drachm. Accordingly it was dispensed in water, with a drop or two of spirits of chloroform added. The object of this dilute chloroform was to prevent the tendency that dilute solutions of salts showed to develop a slight mouldy growth in them.

If the child required, for example, three ounces of milk at each feed, and the physician was giving two grains to the ounce of citrate of soda, the prescription would be six grains of citrate of soda in a drachm of water, to be added to each feed. If larger feeds were taken and more citrate was needed, the same amount of water would be sufficient, for, as above stated, citrate of sodium was very soluble.

Since the writer's first paper in the *Lancet*, Burroughs Wellcome have prepared some convenient tabloids of citrate of soda, but at present they do not seem to be quite so effectual as the fluid, though their convenience to travellers is obvious.

There was one little point about this method simple enough in itself, but not infrequently neglected, which was, that when the amount of milk was increased the citrate of sodium must also be increased in proper proportion. Dr. Poynton used this treatment for ***weaning healthy children where the mother's milk failed, for milk dyspepsia, and for giving milk in a more concentrated form to babies.*** It was remarkable how dilute the milk that was given to children might be, and how long this dilution might be persisted with. Not only this, but where there had been milk dyspepsia, he had known children kept on barley water alone, even for months! If citrated milk was well taken, regardless of the age of the child, he steadily pushed up the strength of the milk, increasing the citrate of sodium in due proportion, until at least two parts of milk were given to one of water. When once this point had been reached, and the condition was satisfactory, the citrate of sodium could be gradually diminished.

This salt was not nasty to the taste, and did not materially affect the reaction of the milk—two great advantages in its use; and, moreover, it was very cheap. One difficulty might arise, and this was constipation, but it could be easily put right by appropriate treatment. His experience of the method was now considerable, for he had used it steadily for about two years. Each child was weighed every week, and the amount of milk and citrate revised in this way. A routine method of procedure was obtained which was a great advantage to the physician and patient. This method did not prove invariably successful, and it was not pretended that it did. It dealt with the curd of milk, and as was well known it might be the fat and not the curd at fault; or, again, cow's milk might be quite impossible for some children, and its use had then to be abandoned. Nevertheless, as a routine and cheap method in the writer's opinion the employment of citrate of sodium was really valuable.

(a) Abstract of a Paper Read at the Leicester Meeting of the B.M.A., July, 1905.

SOME PHASES OF SYPHILIS, ESPECIALLY THE LARVAL SYPHILIS OF WOMAN.

By WILLIAM MURRELL, M.D., F.R.C.P.,
Physician to the Westminster Hospital and Lecturer on Medicine and Clinical Medicine; Examiner in the University of Aberdeen.

Syphilis as seen in London in the present day is, as regards its more obvious manifestations, a much less serious disease than it was thirty years ago. It is rare now to see those extensive gummatous ulcerations of the nose which were common in the early seventies, and are figured in the older works on venereal disease. They are still to be met with in Paris, and at the Saint Louis there are whole rows of syphilitic patients without a nose between them. Our modern development is in the direction of parasyphilitic or metasyphilitic manifestations, which are more pronounced, and make their appearance at an earlier stage than formerly. It is customary to regard tabes and general paralysis of the insane as essentially syphilitic in origin, but it is worthy of note that in Algiers, where syphilis is so widespread as to be almost universal, these sequelæ are practically unknown, and the same, I am told, is true of Russia. In our large towns syphilis for some generations has been so prevalent, that it is possible a partial immunity has been acquired, and in place of the symptoms of the disease itself we see only its after-effects. It might reasonably be anticipated that among Eastern nations immunity would be still more marked, but this is not the case, although the freedom from the influence on the nervous system is notable. It is well known that Englishmen who acquire syphilis in Egypt suffer much more severely, and the disease is of a more persistent type, than when contracted in London. Whether the stories of the "black syphilis" of Japan have any foundation it is difficult to say, but it is probably on a par with the Egyptian and Algerian disease. The explanation commonly offered that it is a "bigger bacillus" may be true in the sense that it is more virulent. There is no doubt that the disease, whilst maintaining its identity and typical features, has varied greatly in its intensity at different times and in different countries, under circumstances the nature and relative importance of which it is difficult to estimate. In virgin communities, such as are still to be found in remote districts of the North of Scotland, the disease, once introduced, rages as a veritable epidemic.

What strikes us most in connection with syphilis, as seen in England, is the mildness of the symptoms in women, especially in private practice. I have seen bad cases even of late years among hospital patients, but they are the exception. I remember in the out-patient department a woman presenting herself with extensive syphilitic caries of the nasal bones, but she was of the tramp class, and had walked all the way from Liverpool to London, sleeping out night after night in bitterly cold and wet weather. I remember, too, a case of extensive rupial sores covering the whole body of a woman of good social position, who contracted syphilis from a man who seduced her, and whom she subsequently shot. She was tried for murder and condemned to death. After lying for many months in a foreign prison awaiting execution, she was reprieved, and when I saw her she was suffering as much from the effects of prolonged anxiety, defective hygienic conditions, and want of proper food as from the specific disease. These cases, however, are exceptional, and the ordinary society woman who contracts syphilis seems to be but little incommoded by her acquisition. I recently saw a young married woman who complained of nocturnal headaches of some severity and duration. She was thin, listless, and anæmic, but complained of nothing else beyond the fact that her hair came out freely. There had been two miscarriages, but no living child of the marriage. The husband admitted that some three years previously, as the result of a visit to Paris, he had contracted a hard chancre on the penis. He failed at first to recognise the nature of the sore, and had connection with his wife. He subsequently underwent an efficient course of treatment and was cured. Believing that his wife had escaped infection, he thought it unnecessary to mention his mishap. I have no doubt that her symptoms were syphilitic in origin, especially as she rapidly improved under the influence of mercury, but there was no history of rash, sore throat, or of any of the ordinary signs of the disease. I am sure that in a large number of cases of chronic invalidism in young women there is a syphilitic taint at the bottom of it, although it may be difficult to prove. These are cases of what may be called "larval syphilis," a condition quite distinct from latent syphilis, in which, after a long interval, perhaps twenty years or more, there may be a severe outbreak of the original disease.

One reason that syphilis is so commonly overlooked in women is that they themselves, as a rule, are but little conversant with its symptoms and course. Men, almost from their school-days, are accustomed to hear the matter discussed freely and openly, and they readily, if at all observant, recognise suspicious symptoms and seek advice. The custom of regarding syphilis as a purely venereal disease and as one associated with sexual incontinence, militates against its proper appreciation and its relationship to other contagious diseases. In so many instances syphilis is contracted accidentally, under circumstances attended with no want of discretion, that it is to be regretted the fact is not more generally recognised. In many cases the presence of some one particular or characteristic sign or symptom will suffice to establish the diagnosis. I remember seeing an elderly maiden lady, the head of a conventual establishment, who called on me about a charity. Her right hand was enveloped in a black silk handkerchief, and she shook hands with the left. I ventured to ask for an explanation, and she told me that for many years she had suffered from a skin affection for which she had sought relief in vain from many of the most eminent specialists in Paris, Berlin, and Vienna. Not without some difficulty I induced her to let me see it, and found that it was a well-marked case of palmar psoriasis. As there were no spots nor patches on any other part of the body, I concluded that it was syphilitic in origin. Under the influence of grey powder given internally and calomel ointment applied locally it rapidly cleared up. I, of course, gave no hint as to the nature of the affection, and to this day am ignorant of how or where she contracted it. Probably a correct diagnosis would have been made long before, had it not been for the eminent respectability of the lady.

In some cases an examination of the blood will throw light on the subject. In the early stages of syphilis, and possibly for a protracted period, the hæmoglobin percentage progressively falls without any corresponding diminution in the number of red cells. At a later stage the patient exhibits all the ordinary symptoms of anæmia, indicated by sallowness of the skin, emaciation, loss of flesh and lardaceous degeneration of the liver, spleen, and other organs. This condition of syphilitic chlorosis is apt to be overlooked, and the anæmia attributed to other causes. Syphilitic cachexia is most marked during the second stage and towards the end of the third. There may be some rise of temperature, and the pulse is rapid, weak, and small. There may be nothing very obvious to account for the condition but headache and pains in the limbs, especially when worse at night, should excite suspicion. It is most commonly in this stage that the patient exhibits instability of the nervous system and becomes hysterical. Many authorities attach importance as a diagnostic sign to the Justus test, which depends on the fact that in cases of contracted secondary or tertiary syphilis a single dose of mercury administered by inunction or injection will, in twenty-four hours, produce a decline of hæmoglobin varying from 10 to 20 per cent., followed in a few days by a rise to a figure somewhat higher than that originally observed. Like other tests of a similar nature, it is open to many sources of error, but it may give useful indications, and is most likely to succeed when oligocythæmia is the prominent feature.

In investigating the history of these cases it is interesting to inquire if at any time a febrile attack has been noticed. Syphilitic fever is, as a rule, not well defined, the temperature rarely rising above 102°, so that although there may be some malaise, the patient is not confined to bed. Exceptionally it may rise to 105°, and I have known such cases sent to the hospital with a diagnosis of enteric fever. The history of a severe febrile attack without any apparent cause is suggestive.

Another common reason for overlooking the existence of syphilis is that the point of inoculation is extra-genital. The best example of this is the digital sore of medical men. It is rarely a defined chancre, and usually there is no induration. It presents numerous varieties, and occurs in so many anomalous forms that its specific origin remains unsuspected, possibly until attention is called to the condition of the nearest group of glands. It need not of necessity be close to the nail, but may be on the dorsum of the finger. Such sores often attain a considerable size, and may be from an inch to an inch and a half across. They are sometimes caused by the scratch of a pin in withdrawing the finger after a vaginal examination. Although hundreds of cases of digital chancre have been recorded in medical men and midwives, it does not appear that nurses suffer in this way, although "bad fingers" are common enough with them. It may be that in women the possibility of specific contagion does not present itself so readily to the mind of the observer as with men. Moreover, if a woman contracts syphilis she is naturally anxious that the fact should not be generally known. It is probable that many nurses get infected, and have no suspicion as to the cause of their deterioration in health. Whatever the explanation may be, these digital sores are rarely recorded in women. In one case a woman contracted a specific lesion on the finger, as the result of dressing a syphilitic sore on a man's face. It is as well to remember that these sores on the fingers are not infrequently multiple.

The primary sore may be on any part of the body, literally from the crown of the head to the sole of the foot. It is not necessary to discuss in detail the primary sores of the lips, tongue, or tonsil, for they are only too common. I recently saw a typical chancre on the lip of a woman, who after escaping many dangers married an elderly clergyman, and in another woman I saw a chancre of the chin inoculated on a burn from a cigarette. That syphilis may be conveyed by infected articles of clothing is positive. Some years ago I saw a man who had a chancre the size of half a crown on the inner aspect of the left thigh. He was a music-hall performer, and had worn a pair of tights belonging to a friend who was incapacitated from taking his part by a "sprain." The sprain was evidently a chancre, and the tights had become infected by contact with the penis. Whether the virus was absorbed by the unbroken skin, or whether there was originally an abrasion, could not be ascertained. Infection has been conveyed by pillows, sheets, towels, sponges, and even tooth-brushes. The custom of lending or interchanging articles of apparel so common among women is not without its dangers, especially when the reciprocity extends to syringes. There is little doubt that the virus can be absorbed by the unbroken skin, especially when the hands and arms are washed in very hot water and a nail-brush is freely used, as is the custom with surgeons prior to an operation. Tattooing is such a fashionable craze that one cannot help suspecting that it is responsible for some obscure cases of syphilis, and it is known that several epidemics of the disease have originated in this manner. It is possible, too, that epilation may be another cause.

There is a common belief that erratic chancres are followed by more severe constitutional symptoms than those contracted in the usual manner. The explanation is that extra-genital chancres escape recognition until a much later period, and the patient is deprived of the benefit of early treatment. The fact of a sore on the penis being multiple is usually regarded as evidence of non-specific origin, but I have seen a man with a dozen hard chancres following an attack of herpes of the penis, each vesicle having been simultaneously inoculated. The female chancre is very commonly multiple, the number varying from two to eight. There is reason for believing that extra-genital chancres are more common in women than in men, some authorities placing the percentage at from 5 to 6 in men, and 25 in women. I cannot help thinking that a grave injustice is often inflicted on women in that they are made to suffer from their apparent respectability. Recently a person of this description, well and happily married, developed symptoms of organic disease of the cord. She went to an "eminent specialist," who, after a careful examination, told her that she was suffering from disseminated sclerosis, a condition, he added, not amenable to treatment. His mental attitude probably was that as the physical signs pointed to a form of sclerosis which was non-syphilitic in origin, she was not suffering from syphilis, and could not be benefited by anti-syphilitic treatment. Recalling something of the lady's past, I was not inclined to attach too much importance to this line of argument, and put her on mercury and iodide of potassium, under which she made a good recovery. It is just as obvious that disseminated sclerosis may occur in a syphilitic subject as that there are cases of tabes in which no definite history of contagion or even exposure can be obtained.

Another source of error arises from the fact that a man who has had a well-marked attack of syphilis thinks that he is immune and cannot contract the disease again. I remember well a man who, in less than four years after an attack of syphilis, for which he was efficiently treated, contracted another hard chancre on his penis, which was not merely a relapsing sore, but a distinct re-infection followed by constitutional symptoms, although of a mild type.

In a considerable number of cases, not congenital, no chancre and no point of inoculation can be discovered even after the most careful examination. Chancres in women are often so small, benign, and ephemeral, that they readily escape observation; moreover, they are less regular in their course than in men.

Cases of syphilophobia are too common to call for comment, but there is another condition to which brief reference may be made. Some time ago an old army man, who was in the habit of boasting rather too freely of his success with certain ladies of his acquaintance, called on me and informed me with ill-concealed unction that he had contracted a hard chancre. An examination of the penis disclosed the fact that he had a sore, but it was equally clear that it had been produced by the application of nitric acid. I suggested this explanation, and he said that he had applied acid to destroy the chancre, a statement I was unable to accept. I told him that there seemed to be little danger of its being followed by constitutional symptoms. He impressed on me very forcibly the necessity of respecting the professional confidence which he had reposed in me, but as several of his club-friends the same evening expressed their regret that he had met with so serious a misfortune, I concluded that he had not been very reticent in the matter. An informal conversation with a lady whose name he had mentioned threw some light on the subject, and suggested that an anaphrodisiac might possibly be of more value than the specific treatment.

In the treatment of larval syphilis small doses of mercury frequently repeated act as an efficient blood tonic, and increase not only the number of red cells, but the body weight. A pilule containing a grain of grey powder and a grain of compound ipecacuanha powder answers every purpose. At first one may be given every four hours, but after a few days one three times a day will suffice. If the pilules act as a laxative it is well to substitute for the compound ipecacuanha powder a grain of compound kino powder, which, although it contains less opium, exerts a more astringent effect. Sometimes the pilules, especially when they have been taken for some time, cause some disturbance of the appetite, and it is then better to discontinue them and rub calomel ointment into the abdomen every night at bed-time. The unguentum hydrargyri subchloridi contains only 10 per cent. of calomel, and is weaker than the blue ointment which contains 48·5 per cent. of mercury, but it is cleaner to use, does not stain the linen, and is equally efficacious. If employed too freely it exerts a purgative action which is to be avoided. Fumigations and hypodermic injections of mercury are quite unnecessary, and it need hardly be said that anything of the nature of salivation should be avoided. Should the gums become even in the slightest degree tender the administration of the drug should be at once stopped, and a mouth-wash used of chlorate of potassium and borax with tincture of myrrh or of listerine, or of equal parts of tincture of rhatany and compound tincture of cinchona. It is hardly necessary to refer to the danger of giving iodide of potassium in this condition, for the mercury is deposited in the animal structures in a more or less insoluble form, and the iodide, by breaking up the combination, suddenly brings the whole of the metal once more into the circulation. In syphilis small doses of mercury prove an excellent tonic, and improve not only the condition of the general health, but also the patient's spirits. The action of mercury as a blood restorative is not continued indefinitely, and the best way of judging of the progress of the patient is to have a periodical blood count, say, once or twice a week. When the mercury has done its work, a non-astringent preparation of iron, one not decomposed by the gastric juice, will complete the cure. Here, again, systematic blood counts should be made, and the erythrocytes ought to increase at the rate of close on 100,000 a day, with a gain of at least 1 per cent. in the hæmoglobin. Attention should be paid to diet and general hygienic conditions, and the treatment should be spread over a period of six months. Open-air treatment in a modified form is just as applicable to syphilis as to phthisis. It is a mistake to continue the administration of mercury for too long, and when the patient fails to make good progress it should be temporarily suspended and iron substituted.

It must not be thought that I maintain that all women are syphilitic, but only that many married women have a syphilitic taint without any suspicion being entertained of the fact. The importance of its recognition from the point of view of treatment is obvious, and it will often serve to clear up many obscure cases.

One word more on a cognate subject. There has been much correspondence in the papers recently about the difficulty in obtaining an adequate supply of soldiers. It seems to me that the wastage to the Army from syphilis alone must be enormous. I am not speaking from the point of view of statistics, but from the common experience of hospital practice. We have always in the wards a considerable number of quite young men suffering from aortic disease, with a fair sprinkling of thoracic aneurysms. In the great majority of these cases it will be found that the patient has been a soldier, and has had syphilis. I have no personal experience of the treatment of syphilis in the Army, but the only conclusion I can come to is that it is utterly inadequate and inefficacious. The hands of the medical officer as far as I can make out, are tied in every way. The line of argument seems to be that either a man is ill and must be in hospital, or that he is well and fit for duty, when he requires no further treatment. Such views are puerile as applied to so chronic a disease as syphilis, and if they are allowed to prevail there is no wonder that men at an early age are invalided out of the service, and that the Army is unpopular.

THE IRISH MEDICAL ASSOCIATION ITS RE-ORGANISATION AND: ITS FUTURE. (*a*)

By G. E. J. GREENE,

Vice-President Irish Medical Association.

IV.

The condition of unrest and general dissatisfaction which has been so noticeable among the members of the Poor-law Medical Service in Ireland, particularly since the passing of the Local Government Amendment Act, has been much canvassed and generally discussed both by those medical men who are not in the service and the public at large; and it is now universally admitted on all sides that (1) the conditions of service are unsatisfactory; (2) the pay is inadequate; and (3) that there is no provision for old age and infirmity in the Poor-law Service. The Irish Medical Association—composed very largely of men in Poor-law service—is exerting itself with the object of, as far as possible, improving matters; but being in a transitional stage itself and consequently much influenced by divided councils can effect little good.

To my mind the Irish Medical Association can do all that is required of it not only for the Service but for every medical man resident in Ireland, whether he hold any public appointment or not!

Now in order that this Association should become the influential body which will be a recognised power to deal with, it must be practically supported by the medical profession, and unless it commands the respect and confidence of that profession it cannot expect its support. Let me briefly outline what seems to me to be the weak points in the Association as at present constituted. (*a*) Its Council is much too large and invertebrate; (*b*) Its Committee of Council instead of being what its name implies, is virtually a Cabinet (I might say triumvirate) dictating the policy of the whole Association. Witness the Evatt fiasco.

If the Association ever hopes to attain influence it must elect for directors its best men (*not necessarily its best talkers*) who are possessed of business capacity and average foresight, and who will not allow religious feeling or political bias to warp their judgments; or self-interest to obscure their views on the democratic question of "the greatest good for the greatest number."

As one of the Re-organisation Committee who signed the majority report I have only to say that I adhere to and endorse that report, which is shortly as follows:—

(1) To abolish the Committee of Council.

(2) To make the Council itself the Executive of the Assiciation and *so small* that it could meet every month. Also that the travelling expenses of Councillors should be paid, and that the election of Councillors should be arranged, as far as possible, so that only the best men who are willing to devote their time and services could be elected.

(3) To strengthen the Association by enabling the branches to return delegates who can attend all the meetings of the Association.

(4) To develop and strengthen the branches so that on all matters of working and policy they should in the deliberations of the Association eventually become the governing power.

With regard to the method of election of Councillors, after considering the question carefully in, I think, all its bearings, I am of opinion that the best men will be obtained by adopting that known as the "provincial area system." It is quite true that it may be urged against this method that it is not sufficiently representative; but what is now most urgently required is a strong Council that knows its own mind and makes it felt both inside the profession and outside of it. If our Council were composed of say, thirty-two councillors (one from each county) does any member of the Association imagine that Council would transact its work in a business-like and connected manner?

A large number could not, and would not, attend. Some holding one view might attend one meeting, others holding an opposite the next and so on.

I think every candidate for a seat on the Council should issue an address in the I.M.A. Journal, stating plainly his views on matters of moment, etc., etc.

And, lastly, I consider that the Vice-Presidents should be abolished, as in most instances they take little interest in the Association and are bad attendants at Council meetings. I may add that it would be well if in choosing the Council of the Association we should consider whether the men we select are diplomatists and what amount of influence they have with the general public. Cranks, no matter what other good qualities they may possess, should not be supported. We must conciliate the general public who alone (through their M.P.'s) can obtain for us all we want.

PREVENTIVE MEDICINE: PAST AND PROSPECTIVE. (*a*)

By H. R. KENWOOD, M.B., D.P.H.,

Professor of Hygiene and Public Health, University College, London.

Professor H. R. Kenwood, after some preliminary remarks, said that the medicine of the future would be increasingly exercised in the direction of keeping patients in health rather than of prescribing for them when sick. Thanks to the press, public health problems were now discussed with intelligence even by the man in the street, and the last person who could afford to neglect any opportunity of keeping himself *au courant* was one belonging to the profession of medicine. The latter owed it to the community to advance the general health, and he could best fulfil

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(*a*) Being the fourth of a series of articles specially communicated to the columns of the Medical Press and Circular by prominent members of the Irish Medical Association.

(*a*) Abstract of Introductory Address at University College Hospital.

this duty by spreading among the masses the knowledge which they must acquire before progress in many diseases could be possible. Increasing use, therefore, should be made by medical students and practitioners of the opportunities afforded by the schools for acquiring a knowledge of hygiene and public health. Many fields of research remained untouched, for the workers were yet few and poorly equipped. The science of public health embraced everything which bore upon the nature and cause of disease, and the real task of hygiene was to teach men how to live healthily under the conditions imposed upon them by social and economic interests, and to point out practicable ways in which adverse conditions could be modified.

If any modern sanitarian, imitating the late Sir Benjamin Ward Richardson, were to describe a city of Hygeia, he would throw the personal factor more, and the sanitary environment factor less, into relief than did his predecessor. The public health policy likely to yield the best results was one directed towards increasing the fitness of the individual to withstand the strain of environment. Sanitary improvements could do much to better the outward circumstances of the people, but they could not amend faulty habits of life; and if ever the Utopian death-rate of 5 per 1,000 was to be obtained a satisfactory standard of healthy and decent living must be adopted by each individual. By the development of a public conscience in matters of sanitation surrounding conditions would be made unfavourable to disease-causing organisms, protective measures would be intelligently applied, and the communicable diseases of the day would gradually disappear.

In an obscure way this conception had already partially been realized. Typhus had practically been exterminated, the mortality from scarlet fever had fallen by 80 per cent. in the past thirty years, and that of typhoid fever by 50 per cent. in the same period. Cyclical diminution in the virulence of certain diseases, of course, existed, but there was ground for believing that some of the diminution would be permanent. Measles and whooping-cough, on the other hand, remained nearly as prevalent as ever, but it was to be remembered that there were economic conditions in modern life—such as the aggregation in schools of children of a susceptible age—specially favourable to their spread. Their control was difficult, but much of the mortality was preventable, and it certainly would be prevented so soon as the masses were adequately instructed on certain points of vital importance.

The science of bacteriology, although still in its infancy, had already done excellent service in the diagnosis of certain specific diseases, by furnishing means of immunisation, by providing cures, by indicating the modes of conveyance of infection, and by aiding in the detection of dangerous pollution in food and drink. It was destined to become a tremendous force in preventive medicine, and the time was coming when every sanitary authority would regard its own well-equipped bacteriological laboratory as the mainspring of its administration; when all but the "conscientious objectors" would avail themselves of the protection afforded by preventive inoculations, and when curative serums would be acknowledged by every practitioner to be the most potent and satisfactory drugs for the cure of infectious disease in his pharmacopœia.

The public health-policy of the country had enormously improved the circumstances of the poorer classes, and had so conspicuously outweighed the evil effect of progressive urbanisation that the general death-rate was now 26 per cent. less than 50 years ago. In this decrease, however, the infant mortality had not shared to the extent even of 1 per cent. This was in any case a serious matter, but when it was considered in connection with the fact that the birth-rate in Great Britain had fallen more rapidly than in any other European country, it became a matter of grave national concern. If the vitality of the nation was to be preserved, the expenditure of infant life must be curtailed. The excessive infant mortality was confined to the poorer classes, and was the result of many and complex forces. Among these were the employment away from home of those about to become mothers, and of those recently confined who should be nourishing their infants, and the great ignorance among women as to the feeding, clothing, and management of infants. Such ignorance and neglect were responsible for the fact that approximately one out of every six children born failed to complete its first year of life.

The domestic life of the working classes was not now what it was, and compulsory school attendance and early female employment away from home had done away with much of the home education of the child nurse. Much of the precious influences and associations of the family and the home seemed to have been lost. This was deplorable, for a child who had never known home-life and motherly solicitude in their fulness had been deprived of that for which nothing in after-life could make amends. Although it was probably true that fewer present-day mothers were able to perform their maternal vocation of suckling their offspring than formerly, it was equally true that a large number deprived the infants of their natural food through selfishness, laziness, and indifference; and for pleasure and self-enjoyment many of the rich and poor alike were ready to sacrifice maternal aspirations and to subordinate maternal instincts.

The proportion of hand-fed to suckled children increased yearly, though everywhere the testimony was forthcoming that children fed from the breast had a prospect of life far in excess of those fed artificially. Even under the most favourable conditions the substitution of an artificial diet was disadvantageous, and the results disastrous, not only as regarded immediate mortality but in respect of those who survived with permanently damaged constitutions. It was the task of preventive medicine to deal with the matter, and to get in touch with the mothers after the baby had made its appearance. The mothers of the future must be educated while under control at school, and while their minds were receptive; and breast-feeding must be advocated, especially among the poor. Certain subsidiary measures to be discarded when better methods became practicable were municipal milk depots and crêches.

While municipal milk depots for the supply of infants' milk were good the radical cure was to be found in clean cow's milk; a pure milk supply was at the present day one of the greatest sanitary needs of the country, and if the educated section of the public only knew the conditions under which milk was drawn in most rural districts it would not be long before it strengthened the hands of those who did already know, and demanded an improvement. In connection with the care of infants the value of lady health missioners was becoming recognised, but medical men also had their duties. A medical man attending a confinement had not completed his duty, either to the patient or to the State, when he had safely delivered the patient and handed over the child to the nurse. Detailed instruction was required as to its feeding and management.

Other work for preventive medicine lay in attempting to abolish the prevailing ignorance regarding the cookery and selection of food. It was both useless and cruel to attempt to educate a child whose body was ill nourished. Even if all the children arrived in school in good condition, preventive medicine still had its task. The cultivation of child life in school at school ages was a highly artificial process for which Nature had made no provision. Even under the best conditions it must be carried on to some extent in defiance of her laws, and to reduce the resulting evils to a minimum continuous medical inspection of the children was essential. It was a national shame that England seemed likely to be the last nation to make provision for the latter. To all objections raised he could only reply that what was found easily practicable in Germany, Japan, and elsewhere must be practicable in our own country.

The hygienic reform of the future depended almost entirely on the proper education of the people. Given this, many existing hygienic evils would cease; and proper education should include likewise the training and education of girls for the functions which awaited them. At present the sarcastic comment of Herbert Spencer on the absence of any instruction likely to be useful to future parents still had full application.

Dealing with phthisis, it was easy to understand why the disease should be one of the leading causes of pauperism, for each of the 17,000 deaths amongst males at the 20 to 50 age-period of life was preceded by three years of illness on an average. To control it in any way, compulsory notification was necessary, and to obtain the best broad results reliance must be placed less upon sanatoriums than upon continuing to improve the general conditions of life. Consumption must be met by different measures for its different stages; sanatorium treatment with a view to cure, or education in how to manage his disease of the man in a very early stage, and isolation for the one whose every cough disseminated tubercle around him. The selection of suitable employment for those predisposed to the disease was also of much importance.

The solution of many public-health problems depended upon the solution of the problems which were social and political. The former, moreover, changed with altered circumstances, and new ones were constantly evolving; many of the old were becoming more complex year by year, and some were so dependent upon a high ethical level among the general public for their complete solution that only the millennium could be expected to see them solved. The public health worker, therefore, could never hope for a complete realization of his ambitions, and to his labours there could be no end. But his reward was the satisfaction of witnessing almost daily beneficent results from his work, and it was from this that he drew his stimulus.

Does the road wind uphill all the way?
  Yes, to the very end.
Will the day's journey take the whole long day?
  From morn to night, my friend.

Clinical Records.

ROTUNDA HOSPITAL, DUBLIN.

A Case of Cæsarean Section (Second Operation).

By Gibbon Fitzgibbon, M.D.,
Assistant Master, Rotunda Hospital.

A. P., æt. 30, para. II., was admitted on August 6th. Her previous history was that in June, 1900, she had been in hospital with her first pregnancy. At that time she came in some hours after labour had started, and on examination the child was found to be presenting as a brow, the head being still free above the brim of the pelvis and the os admitting two fingers.

The pelvis was measured with Skutch's pelvimeter and the conjugata vera found to be only 7¼ c.m. Cæsarian section was decided upon as the mode of delivery, and this was performed by Dr. R. D. Purefoy. The child a female, 7¾ lbs., was delivered alive and both mother and child left hospital a month later. No pregnancy had occurred since this until the time when patient returned to hospital. She was then at term, the actual date of last menstruation was uncertain, but it was some time about the middle of November, 1904.

At the time of admission to hospital the patient stated that she had been having pains chiefly in the abdomen, but occasionally occurring in the back for over twelve hours These, however, disappeared from the time she was put to bed, and did not recur. On palpation the fœtus was found lying obliquely, the head being in the right iliac fossa. No uterine action was going on, and as the time was late at night, it was decided to wait until the following morning and then perform Cæsarean section.

The patient was prepared in the ordinary manner for laparotomy, and although there were no actual signs of labour having started it might be expected to do so at any time as the patient was evidently up to term.

Operation:—The abdomen was opened with a six-inch incision made slightly out of the middle line, so as to avoid the scar of the previous operation. The uterus presented, and was found to be twisted on its vertical axis so that the right broad ligament ran obliquely from the left side of the abdominal incision above, downwards to the right iliac fossa. This was found to be partially due to a dense cord-like adhesion running from the uterus to the previous abdominal wound. This was divided, and then the uterus held so that the anterior wall presented in front.

The uterus was opened through the previous scar, and the placenta found to be directly under the incision was partially cut through, and the child delivered through the placenta.

The uterus was then lifted out of the abdomen and bleeding controlled manually by an assistant. The upper part of the abdominal wound was closed with a bullet forceps to prevent the escape of the intestines. The placenta and membranes were at once stripped off the uterine walls and the uterus enveloped in towels wrung out of hot water. The suturing of the uterine wound was started immediately, and was done with No. 4 silk interrupted sutures placed about three to the inch and including all the uterine wall from the peritoneum down to, but not including, the endometrium. A gauze sponge was left in the uterus during the suturing. This was removed and the uterus douched out before closing the last few stitches, and then replaced in the abdominal cavity. The Fallopian tubes were then tied in two places, having stripped the ligatures away from each other so as to give about an inch between the two points of tying, and then the tubes divided with the object of producing future sterility. When this was completed the closing of the abdomen was at once started. The peritoneum closed with continuous No. 2 silk suture. The external rectus fascia with continuous No. 4 silk, and the skin with a subcutaneous silkworm gut suture. Before completely closing the peritoneum the abdomen was washed out with normal saline solution and about two pints of this allowed to remain in the abdominal cavity.

The patient made an uninterrupted recovery, the temperature on the second day rising to 100·6, and except for this one occasion never being above 99·4. The pulse only once reached 100.

The skin suture was removed on the ninth day, the abdomen being completely healed, and the patient left hospital with a healthy male child on the twenty-eighth day.

Owing to the immunity from contracted pelvis which exists among the women of Dublin, Cæsarean section is not very often necessary, and the opportunity of performing it for a second time on the same patient does not often occur. I think it may be of interest to record the condition found resulting from the first operation. The abdominal wound which had been closed by through-and-through sutures had united perfectly. The scar in the uterus had stretched considerably, and caused a much thinner portion of uterine wall than the surrounding tissue. The incision was made through the old scar, but close to the edge, and the placenta was found directly beneath, part of the placenta being attached over the whole of the scar tissue in the uterine wall, but this position had no effect whatever on the character of the adhesion between the placenta and the uterus, nor on the controlling of hæmorrhage from the uterus by sutures. An interesting condition occurred from the contraction of the uterus which took place, while inserting the sutures, one side of the wound increased in thickness to about two inches, while the other side which contained most of the old scar, only increased to about half an inch. This made the apposition of the two sides a little difficult, and shows that the uterine muscle does not tend to be reproduced when it has been injured or destroyed. A question arose in this case as to whether it would be better to wait for the obvious onset of labour or to operate without it. I think there is much in favour of not waiting in a case where Cæsarean section has been done before, as by this means the risk of stretching and perhaps rupture of the old scar is avoided, in the event of labour commencing perhaps at night when there would probably be delay in getting everything ready for a laparotomy; and also the patient can be properly prepared for a laparotomy, and the operation will be performed in daylight. I think this case shows that there is no need either for labour to have started in order to make the uterus contract when it has been emptied of its contents, or to have dilatation of the cervix for subsequent drainage, as in this case the internal os was found tightly closed when the uterus had been emptied.

Transactions of Societies.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

First Meeting of the Session, held Oct. 6th.

The President, Mr. L. A. **Bidwell**, F.R.C.S., in the Chair,

who delivered the Presidential Address on

THE PROGRESS OF INTESTINAL SURGERY.

After a brief review of the history of the surgery of this region, in which he gave an account of the almost accidental but successful resection and suture of a piece of intestine by Ramdohius in 1727, he pointed out that the advances made during the past thirty years were so extraordinary that they seemed almost beyond belief, and he traced these advances to the advent of anæsthetics, the work of Lord Lister, in the field of antiseptic and especially of aseptic treatment of wounds, an improved knowledge of the anatomy and physiology of the organs contained in the abdomen, which showed to what a great extent they might be interfered with without damaging the health of the patient, and, lastly, the discovery that with cleanliness it was by no means dangerous to open the peritoneal cavity, but that the rapid manner in which peritoneal surfaces adhered to one another, and the way in which it was able to deal with even a considerable amount of even semi-purulent fluid, entitled it to be called rather the surgeon's friend than his enemy. Another thing which had contributed to their progress had been the recognition of the proper methods of suturing gut; and the lecturer paid a fitting tribute to the work in this direction of Lembert and Halstead. Reference was also made to the ease with which hæmostasis is now obtained by Spencer Wells forceps, and the methods of combating shock by means of saline injections and heated operating tables, both of which are of no small assistance to the abdominal surgeon in attaining his present good results.

In the course of a rapid review of the present attainments of the surgeon in the abdomen, it was noted that two former Cavendish lecturers of the Society had been the means of making epoch-making advances, the late Professor Mickulix having been the first in 1880 to operate successfully for perforating gastric ulcer, while Sir Frederick Treves, in 1887, first recommended the removal of the appendix during the interval between two recurring attacks.

A hearty vote of thanks to Mr. Bidwell having been moved by Dr. Culver James, seconded by Dr. Campbell Pope, and carried by acclamation, the proceedings terminated.

NORTH-EAST LONDON CLINICAL SOCIETY.

Clinical Meeting held Thursday, October 5th.

Mr. C. E. Hutt, President, in the Chair.

The following cases and specimens were exhibited:—

Mr. **Herbert Carson** showed (1) a man, æt. 47, with a swelling in the neck of a glandular character. In the opinion of the exhibitor it was regarded as malignant in nature, probably akin to the "potato-tumours" which had been described by Hutchinson as growing from the carotid body. The patient had been under potassium iodide with the result that the glands on the left side had disappeared, but those on the right side were apparently increasing in size. At the present time he was taking arsenic. The advisability of operative procedure was discussed.

Dr. **Basil Price** remarked that the stony hardness of the glands and their matted feeling suggested the idea of lymphadenoma.

(2) A case of Malignant Disease of the Tongue in a man, æt. 52. The case was considered unsuitable for operation owing to the advanced state of the growth, which had bound the tongue firmly down to the floor of the mouth. Glandular implication was very considerable.

(3) A case of Tuberculous Disease of the Shoulder-Joint in a man, æt. 41. An abscess had developed thirteen years ago at the front of the left shoulder which had been opened. It was now proposed to admit the patient to hospital with a view of endeavouring to obtain for him a movable and useful form of joint.

(4) A young man, æt. 27, with a swelling upon the eighth and ninth ribs upon the left side. There was no history of syphilis. The condition had been noticed for eight weeks. The skin over the swelling, which was in the post-axillary line, was reddened, but there was no marked tenderness. The diagnosis lay between a sarcomatous growth and tertiary syphilis. In view of the fact that the swelling presented an abrupt edge the former was considered as being more probable.

Dr. G. P. **Chappel** showed specimens of ulceration of the intestine from a case of typhoid fever in a girl, æt. 17. The case had been a very severe one, perforation having taken place at about the end of the second week for which laparotomy had been performed. There had been little or no abdominal tenderness, and spots had appeared only three days before the perforation.

The **President** stated that he had seen the case before its admission to hospital, and it was rather remarkable that the first symptoms had been swelling of the legs. The case resembled somewhat one of rheumatic fever.

SOCIETY FOR THE STUDY OF INEBRIETY.

Meeting held Tuesday, October 10th, 1905, in the rooms of the Royal Medical and Chirurgical Society.

Norman Kerr Memorial Lecture.

Professor T. D. Crothers, delivered the First Norman Kerr Memorial Lecture. The lecture was preceded by a reception by the President and Council of the Society for the Study of Inebriety and followed by a conversazione. The following is an abstract of the earlier portion of the lecture:—

All scientific pioneer work brings into prominence two distinct classes of leaders. Those who go far beyond the present ranges of their subject, taking advanced positions, and defending themselves vigorously. Such persons are commonly treated with indifference, and denounced as cranks and impracticable men. Dr. J. Edward Turner, of America, who founded the first inebriate asylum in the world, was an example of this type. The second class work along modern lines, and beyond the frontier of the present, but always remain in close touch with that frontier. They organise fresh truths, materialise new and old theories, and direct public attention towards them. Dr. Norman Kerr belonged to this second class. His life and work were devoted to the promotion of the scientific study of inebriety. To consider inebriety as a disease was a very ancient view; that is noted in the writings on the buried tombs of Egypt many thousand years before the Christian era. The idea, although repeated through the centuries which followed it, attracted no attention.

The first distinct scientific study of inebriety was made by Dr. Rush, of Philadelphia, in 1809; other investigators followed with essays and papers, but not until 1844, when the British Lunacy Commission spoke of inebriety as a disease, did this subject attract any particular attention. Dr. Turner organised an inebriate asylum at Binghampton, New York, which was opened in 1863, and this was the first institution of its kind in the world, and the first scientific effort to demonstrate that inebriety was to be treated as a morbid condition. It attracted a great deal of attention, and was the centre of opposition and controversy. The influence of this institution extended to all civilised countries, and in England lead to the formation of a committee of inquiry in the House of Commons, to consider the best plan for securing the care and control of habitual drunkards. The bitter opposition and controversy which followed, and the death of its promoter, Dr. Dalrymple, left the subject in a confused stage. It was at this point that Dr. Norman Kerr appeared and took up the work. Born in Glasgow in 1834, he graduated at that University in 1861. Previous to this he had had large experience as a journalist, and after his graduation he served for many years as a surgeon on the Allan Line of steamers.

He was a practical temperance man in his early life, but on coming to London in 1874, he took up the subject of the scientific study of inebriety, and its cure in suitable institutions, and was a most enthusiastic student in this new field of activity until his death in 1899.

He early became a keen worker for the promotion of legislation for the care and control of habitual drunkards. He was not only energetic in inspiring others, and uniting leaders in the profession to influence Parliament to enact laws for the organisation of institutions with legal measures for control, but he succeeded in establishing the Dalrymple Home, which was opened in 1884. Later he continued to be very active in advocating the legal control of all institutions for the care of inebriates. In 1884 he founded the Society for the Study of Inebriety, and was its president until his death. This body has been a very prominent factor in turning public opinion towards the scientific study of the subject. Its proceedings have been numerous, widely read and copied, and have formed public opinion to a large degree.

In 1887 Dr. Norman Kerr organised and conducted an International Congress for the study of inebriety. Prominent men from many countries read papers and discussed the subject for two days; this gave it a position in the scientific world which did much to change public sentiment and overcome considerable opposition. Two years later Dr. Kerr issued a work on "Inebriety; its Pathology and Treatment," which has been a recognised authority on this subject up to the present time. Its particular value was in the general treatment of the subject giving a masterly survey of the whole field without exhausting any particular phase. In some respects it was an unusual contribution to science, particularly in the grouping and arranging of facts and statements, and stimulated many writers to further study and examination. This work, together with numerous essays and papers contributed to the medical and secular Press, gave Dr. Kerr great prominence, and brought clientage and correspondence.

Dr. Kerr was a very voluminous and graphic writer, and his scientific grasp was very apparent in all that he wrote. Some early papers on stimulants in hospitals, the mortality from drunkenness, and the two "Wine" theories in the Bible are good examples of his style. As a leader of men he possessed the rare faculty of stating his own views and conclusions in a manner that neutralised all opposition, and if he did not always convince his hearers and those who differed from him, he invariably secured their respect. He was a man of great ability as an organiser, and knew how to direct his own studies as well as those of others, and so arrange the facts of science that they would appeal to the largest number of persons and rouse an interest to make further inquiries. In all his books and papers the necessity for a scientific study of the alcohol problem was urged in the most practical way, and along eminently conservative lines. While broad and liberal in his recognition of facts, he never advocated extreme theories or urged irrational measures, but always sought the most practical means and methods. As a reformer he was greatly interested in new movements of thought and action, but in all he was the scientific man, judging scientifically.

Dr. Kerr's writings were very influential in America. He sought to promote medical interest in the scientific study of inebriety and to take the subject out of the hands of quacks and irregular practitioners. In a quiet way he succeeded in overcoming great opposition and concentrating interest. His real work was in gathering up the facts concerning inebriety and materialising them into practical legislation and institutions and presenting them in literature. This pioneer work has made it possible to understand the inebriate and in some measure to neutralise and prevent the evils. He set men thinking, turned the tide of philanthropic temperance work into new and broader channels, giving it a new vitality and a fresh direction, the result of which is already felt in all the civilised world.

This memorial meeting is not only a personal recognition of his life and work, but marks the beginning of a great advance along new and broader lines of research. An approach of the alcohol problem from the scientific side promises many new revelations of practical means and measures for the prevention and cure of inebriety.

CENTRAL MIDWIVES BOARD.

Meeting held October 5th.

Dr. Champneys, President, in the Chair.

The proceedings opened with the reading by the Secretary of letters from medical officers proving that two midwives of their districts were uncertified through delay on the part of the local Board in sending in the application. It was agreed to admit their claim, a concession which was afterwards referred to by Sir William Sinclair.

It was agreed to appoint one or two medical men of the Board to assist the examiners at the ensuing examination, Dr. Dakin being chosen as one of them. The examinations for London and the provinces to be every two months, beginning February 6th, 1906.

Mr. Ward Cousins, in moving "That the resolution of the Board of March 23rd, 1905, refusing the request of the Belfast Maternity Hospital for the recognition of its certificate as an approved qualification under Section 2 of the Midwives Act, be rescinded"; and in the event of the above resolution being carried:

"That the application of the Belfast Maternity Hospital for the approval of its certificate as a qualification under Section 2 of the Midwives Act be granted," said he knew all the members of the Board were anxious to be just, but he could not help feeling that the midwives of the Belfast Maternity had been very harshly treated. It was hard that those women who had been well educated and approved by a medical staff to fill appointments in Ireland should be excluded. All the other maternity charities had been accepted, and why those unfortunate women should be excluded he could not imagine. They had had an important training and passed their examinations, yet were not to rank as some thousands of women who had had no training. On February 14th, a letter was sent asking for recognition, and on March 23rd, the matter came before the Board, and it was quite within the purposes of the Act that these women should be admitted. He felt very strongly, that they had been unkindly treated and the position should be revised. The Act distinctly said that those who have received good training should receive consideration.

Sir Wm. Sinclair, in seconding the motion, said there had been no reason given why the request had not been complied with. He maintained the Belfast Maternity Hospital had been treated illegally. A request for recognition had been sent to the Chairman of the C.M.B. on October 4th, 1904. On March 23rd the whole thing was passed over with a remark by the Chairman that it was too late. In view of the resolution he was much interested in those midwives who had applied too late. It was a claim put by one of the very best hospitals and no reason had ever been given from first to last for refusal. It was simply the will of the Board to do this illegal act. There had been a legal act in applying for recognition on February 14th and there was nothing to be said against it. At the beginning of the present meeting they had allowed the claim of two women whose application had not been duly sent in through no fault of their own, yet here in the case of some fifty well-trained women who had doubtless imagined the application of their Hospital Council to be sufficient, no allowance was to be made.

The **Secretary** remarked that Dr. Byers, representing the Belfast Maternity Hospital, had expressed himself as satisfied that those who applied before April 1st should be accepted, whereupon

Dr. **Ward Cousins** added that if the Board went back one step and accepted one, all the fifty ought to be admitted, but

The **Chairman** said he did not see why they should do more than Dr. Byers asked for.

Mr. **Parker Young** then proposed an amendment to Mr. Ward Cousins' resolution: "That those who had applied should be recognised."

Sir W. **Sinclair** urged it would be more dignified to accept all the midwives, or it would create a sense of injustice through all the north of Ireland. Dr. Byers did not represent the whole of the nurses.

Mr. **Parker Young** contended that it was not necessary to give them what they had not applied for. Clearly Belfast had not taken the same interest in the matter as the Rotunda and the Coombe Hospitals.

For the amendment four votes were given, the Chairman also voting on that side.

Three votes were against it, and

The **Chairman** remarked that as to the illegality of their conduct they were given their choice, and had made it to the best of their ability. How could anyone know better than Dr. Byers what the nurses wanted? A concession would embroil all other cases brought up.

Sir William Sinclair and Mr. Ward Cousins then left the meeting, and

Mr. **Parker Young** moved: "That in future the minutes of all Committees shall be kept and taken as read at the next meeting, and put as a correct record of what passed at the previous meeting," which was seconded by Miss Paget, and passed.

Miss **Paget**, seconded by Miss **Wilson**, moved that "With a view to the better despatch of business, communications on any one subject shall not, unless new matter has been submitted, be brought before the Board more than twice, but shall be dealt with at the discretion of the Secretary, in consultation with the Chairman," but

Mr. **Parker Young** objected on the grounds that there were many documents of serious import which had to be brought up several times, or a reiterated objection might be brought up again and again by a midwife, which would constitute "new matter," Moreover, it would be putting too much responsibility on the Secretary.

France.

[FROM OUR OWN CORRESPOENT.]

PARIS, October 8th, 1905.

ROTHSCHILD'S HOSPITAL.

This hospital, although it is open to all classes independent of nationality, appears to be very little known in England. Founded as it is on a charitable basis, it differs from other institutions of the kind, inasmuch as pecuniary aid is given to patients when necessary on leaving it, and lying-in women are furnished with the layette for the coming child. The staff consists of the Principal Medical Officer, Dr. Kahn (son of the Zadik Kahn, Grand Rabbi for France), who is a prominent physician, and who fills various other responsible posts. The chief surgeon, Dr. Reblaud, is known as a brilliant operator, to whose perseverance the hospital is indebted for the modern and up-to-date instalments of the different sections under his control, Dr. Lehman, physician; Dr. Amado, obstetric physician; and Drs. Lazard and Cruccanu, as house physician and house surgeon, with another staff of visiting physicians and surgeons. In the hospital there are three wards (men), two medical and one surgical of 32 beds, and award for isolated cases under observation, but contagious diseases are not admitted. Two children's wards, each of sixteen beds, for boys and girls respectively. Two rooms for confinements, and a lying-in ward, in which women are kept after delivery a fortnight (bar complications). Two other wards of sixteen beds each for women, and an operation room with modern fittings. In connection with the latter, however, it may be stated that, owing to the suggestion of Dr. Kahn and Dr. Reblaud, other necessary additions are in contemplation, but the management of the hospital being in lay hands, necessarily ignorant of the scientific needs of modern medicine and surgery, their accomplishment is a matter of time. Beside the before-mentioned departments there are special wings for radiography, bacteriology, polyclinic, dentistry, ophthalmology, laryngology, otology, and urology. Each of these has its own bath room, kitchen, and lavatory. In the same enclosure, under the same superintendence but separated from the hospital there are an orphan asylum and an asylum for incurables (men and women). Patients from all parts flock into this noble institution, English, Russians, Germans, Italians, Roumanians, and Turks; yet it is entirely kept up by voluntary donations, on which account I appeal, as a medical man, to my English *confreres* and philanthropists generally not to forget this establishment when visiting Paris, as an adequate idea of the real charity therein administered can only be found by personal knowledge on the spot.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 8th, 1905.

DEATH BY ELECTRICITY.

The *Deutsche Med. Zeitung*, No. 73, has a paragraph referring to two deaths caused by contact with a "live" electrical wire. The chief interest lies in the declaration that such accidents are not necessarily fatal, and the opinion that the first case would not have been fatal if artificial respiration had been properly performed and persevered with. A youth of 10, strong and healthy, just to amuse himself, thoughtlessly touched a wire that ran into ground and that generally was not alive. Occasionally, however, a current of 500 volts ran through it, as its use was to carry a current to earth on occasion of some break in the insulation. He first touched the wire with his finger tip, then with the whole of the right hand without saying anything—and it is supposed, without feeling anything. He laid hold of it again and immediately called out, was seized with convulsions, and fell against the wall. Several minutes elapsed before he could leave go of the wire, and on doing so fell down unconscious, but still breathing feebly. The bystanders attempted artificial respiration, but no medical assistance was sent for. The autopsy showed no burning of the skin, a comparatively bloodless brain without œdema, several petechiæ on the heart, moderate fulness of the right heart, tenseness of the vessels behind, filling of the large vessels with fluid and clotted blood, moderate frothy œdema of the lungs, nothing characteristic, in short, except the signs of suffocation.

It was ascertained that immediately after the tragedy the wire contained no current. It was assumed among the technical experts that the accident was due to a so-called "vagabond current," such as sometimes branched off from the main current in wet weather, The author was convinced that with artificial respiration properly conducted under the direction of a medical man, the boy's life might have been saved, in the same way as in a case pointed out by D'Arsonval, where a man who had received a current of 4,500 volts, and who had been unconscious for hours, was saved.

The second case was that of an electrical artificer, who by coming carelessly into contact with a transformator and not in the regular current circuit, but near to it fell forward with a cry of pain and was dead. The autopsy showed burns on the arm affected, bloodlessness of the brain, a good deal of œdema of the pia mater, a flaccid empty heart, and excessive hæmorrhagic œdema of the lungs. In this the cause of death was cardiac and not from suffocation. In both cases the wire in question was not protected by insulation. The author points out that in all parts carrying a high tension current efficient insulation should be demanded.

The *D. Arch. f. Klin. Med.*, 84, 1–4, has an article by Dr. F. Mertsch on

Aspirin as an Analgesic in Gynæcology and Midwifery.

It has been used successfully in a series of cases of a non-rheumatic nature (carcinoma of the uterus, of the stomach, locomotor ataxy). During the last eighteen months it has been used in the most varied conditions, even in obstetrics.

In one case of large, nodular painful myoma in a lady, æt. 69, gramme doses twice daily gave relief. It was also successful in painful after-pains—three one-gramme doses at hourly intervals. Also in long persisting after-pain—one gramme doses thrice daily did good.

There did not appear to be any tendency to become used to the drug, so that it lost its effect. An identical effect was produced by the cheaper acid acetyl-salicyl, the latter being practically aspirin without its " fancy," name. As a matter of fact, we are getting inundated with " fancy " names of drugs.

Eclampsia.

After the discussion on eclampsia at the Leicester meeting of the B.M.A., at which, by-the-bye, absolutely nothing new or even suggestive was said, something from a German source may prove of interest, especially as it is not quite so threadbare as the utterances at the meeting in question.

Dr. Dienst has a paper on the subject in the *Zeitsch. f. Gynækol.*, 1905, in which he describes certain experiments he made with a view of some elucidation of this dark subject.

When he injected milk into the umbilical vein attached to the placenta of an eclamptic woman, the milk poured out of the large vessels of the maternal surface of the placenta. When, immediately after the birth of the child and before separation of the placenta, he injected a small stream of methylene blue into either an umbilical artery or vein under the lowest possible pressure, 20 per cent. of the women passed urine that was blue. In 24 cases the mothers' blood agglutinated, the blood corpuscles of the blood of her own child and at last dissolved them. Fifteen women in whom the placenta was impermeable remained healthy; nine women whose urine became blue became ill, seven of them being attacked with eclampsia and two with albuminuria. Eclampsia and albuminuria, therefore, took place, as he says, from the mingling of the maternal and fœtal blood, which on this occasion behaved like the blood of different species. After the autopsy on one of the patients dying of eclampsia, methylene blue was injected into the vessels of the cord of the still adhering placenta. Immediately after the injection of only a few cubic centimetres, the blue colouring matter issued out of the uterine veins. It was remarkable that in all cases of eclampsia ending favourably the power of agglutination was very much increased about the fourth or fifth day, whilst this power was absent in the fatal cases. The intoxication in eclampsia was therefore the following: A pregnant woman, whose blood by its great richness in anti-material was different to fœtal blood, suffered some placental lesion from some cause or other, and some fœtal blood got into that of the mother. The maternal blood provided with agglutinin causes agglutination of the fœtal blood, and thereby is caused blocking of vessels. The agglutinated fœtal blood quickly dies, and the hæmoglobin of it becomes mixed with the maternal plasma. Numerous clots are the consequence. If the hæmoglobin is excreted by the kidneys the woman recovers, if the formation of such hæmolysones does not take place, when the resorption of the stroma fibrine from the fœtal blood, the heterogeneous protoplasma molecule becomes fixed in the receptors in the maternal blood, and destroy the blood corpuscles whereby free hæmoglobine is formed in the maternal blood and a *circulus vitiosus* is formed.

On the other hand Liepmann declares that the separation of villi takes place on the slightest injection pressure.. That the fœtal blood can mix with the maternal is highly probable, but this does prove any connection between the mixing and maternal eclampsia. Dienst's allegation that the blood of cases recovering had a strong hæmolytic action was in contradiction to the results of experiments made by Liepmann himself.

Schenck has also written on the same subject, and his experiments are remarkable as showing a constant increase of hæmoglutines in childbed. If this were due to passage of fœtal blood into the maternal circulation, it would be met with in normal pregnancy, as the fœtal blood certainly passes into the maternal circulation. This is not the case, however; and the increase in hæmoglutines is never met with in pregnancy, but only during childbed, after the pregnancy is ended. It is due therefore to absorption.

Whilst on the subject I may mention another communication regarding the biological origin of eclampsia It may not amount to much, but it may clear the way to the acquirement of knowledge by brushing aside what we know to be useless theories. Askoli and Weichardt in the *Zeitsch. f. Geburtsh and Gynækol.*, allege that fœtal villi are often found in the maternal organism without eclampsia taking place, that in early abortions when so many fœtal villi are present in the maternal circulation eclampsia never occurs. The fact that primiparæ are particularly prone to eclampsia, speaks by no means in favour of the biological theory. Again it is not by any means decided which is the primary occurrence, and whether the deportation of villi is not a sequence of the eclampsia as albumin in the urine undoubtedly is at times. Another fact that tells against the biological theory is this, that in cases of tubal abortion where masses of villous material are lying in the abdominal cavity, they never cause eclampsia. The cause is unfortunately as much enveloped in mystery as ever.

Austria.

[From our own Correspondent.]

Vienna, October 8th, 1905.

Anti-ferment.

Weinland has published his experience in his laboratory research for anti-ferments in the stomach and bowel, which have long been assumed by physiologists though not actually proved. It is well-known that parasites exist in both the stomach and bowel, such as the nematoda trematoda, cestoda, and acuntocephala, and thrive with perfect immunity. Even the cystacerci resist the influence of the pepsin and gastric secretions of the stomach, although the pale portion of the body may be acted on the head and neck always survive. It is remarkable that the latter in the sheep is not digested in its transit, through the stomach and bowel by the proteolytic ferments known to exist in the alimentary canal.

Weinland's experiments were conducted with the ascaris milla, who concludes that these parasites are protected in their course by an anti-ferment. By fractional analysis he obtained an extract from which, by the addition of alcohol, he obtained a white, mealy, and glutinous deposit, soluble in water, which, when applied to dead tissue, preserved it entire against the proteolytic action of pepsin and tripsin. It had also the same protective power for fibrin. This substance does not seem to be a simple body as it is both anti-trepsin and anti-pepsin. When in solution with the ferment the action of the latter is not destroyed, but is inhibited; after months in solution, however, the various substances cannot be distinguished. How this antiferment is formed in the parasite he will not venture to speculate, but it is presumably to be found in the cells, though not in chemical combination with the albumen. This protective property was first assumed by Frenzel, who asked if such an anti-ferment could exist in the stomach and bowel?

His experiments on pigs had a similar result. The same alcoholic precipitate contained the anti-tripsin in both small intestine and stomach. This anti-ferment he considers to be in combination, though not chemically, with fibrin, that may gradually become alkaline, and the solution lose its active property. He concludes that this anti-ferment may be accepted as a protection to not only worms, but all other parasitic germs in the alimentary canal, which may be subjected to the proteolytic ferment of the organ.

After showing a similar arrangement in plants, such as the drosera dionäa, &c., he asks how this anti-ferment is produced. Is it in the canal of the parasite or in the cell of the protozoa, or is to be found in the wall of the canal where it accumulates, or is it a modified inactive constituent like zymogen, which is present in the blood. Knowing that the blood contains such an anti proteolytic substance, it is reasonable to assume that this will be imparted to the secretions and eliminated in the same manner. It is thus antagonistic to the proteolytic action of the secretion, and may be a modifying or protecting agent in the destruction of albuminoids. According to Weinland's theory, the walls of the stomach would secret an anti-ferment as well as pepsin. The anti-ferment would functionally act as an eclectic protecting the walls of the stomach, and other proteoid bodies from digestion or decomposition taking place in the mucous membrane of the organ.

Chronic Manganous Intoxication.

At the Prague meeting of the Austrian faculty, Jaksch exhibited a case of manganese intoxication in a worker from a potassium permanganate fabric, whose symptoms were of a protean nervous character. Exophthalmia was a prominent symptom, although every other symptom of morbus Basedowii was absent. Romberg's phenomenon appeared at another time in a modified form. On closing the eyes he could stand perfectly steady, but after half a minute would fall backwards; still later the gait became hen-like and spastic in movement. The sensibility, speech, and caligraphy were normal, while the reflex was slightly exalted. The right arm was somewhat weaker than the left, although there was no trophic disturbance.

In two other cases of a similar nature which he reported in 1901, where speech was affected, Romberg's symptom present, with a forced smile on the face and increased reflex he reported a great improvement in all these morbid conditions, as well as a number of other cases that had come under his notice, but were not reported. He characterised the disease as one peculiar to the trade of manufacturing potassium permanganate from the mineral "braunstein," which contained in combination manganous and manganic oxide. some years ago the manganous oxide Mn_2O_2, was separated from the manganic, Mn_2O_3, by HCl, but since the change, this nervous disease has been very common among the workers, which may be inferred from the absorption of the manganous oxide.

The pathological anatomy seems to be a degenerative change in the peripheral nerves, probably from its contractile property. The brain and spinal cord seem to be similarly affected, producing a sort of pseudo-sclerosis as understood by Westphal.

Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, October 8th, 190

At the recent meeting of the Budapest Inter-hospital Association, Dr. Karsay gave an excellent summary of the views held at the present day on

Tuberculosis and Pregnancy.

He also related five cases which came under his observation. He states that pregnancy is a severe complication of tuberculosis, the severity of which increases with each pregnancy. Important among the prophylactic measures should be the prevention of conception among tuberculous women. If pregnancy has taken place the woman should be kept under careful medical observation, and if the tuberculous disease grows worse, abortion should be strongly recommended. During the later months of pregnancy the induction of premature labour does not offer any advantages over labour at full term, and is fraught with seriousness for a tuberculous patient. Moreover, as a tuberculous mother may give birth to a healthy child with fair chances of good health later on, it would be unfair to needlessly sacrifice the life of an infant. He does not believe in universally interrupting the pregnancy as advocated by Maragliano and Hamburger.

Radium in Ocular Therapeutics.

Dr. Farkas gave the following conclusions:—(1) Radium in external application is a very powerful analgesic, especially for neuralgia, rheumatism, iridocyclitis, and the severe pains of inoperable cancer. (2) Application of radium can produce a rapid absorption in the interior of the eye, such as an old hemorrhage of the vitreous body, absorbed in ten days. (3) Certain results are obtained in blepharitis. The results obtained from the action of radio-active salt of radium, internally and externally, permit the hope that it will soon be possible to sooth gastric or intestinal pains of nervous origin from ulceration or from cancer.

Permanganate of Potash as an Antidote for Morphine.

Dr. Mir explained the action of permanganate of potash as the true chemical antidote of morphine. If a certain amount of permanganate is added to an aqueous solution of albumin, a dark brown, homogeneous fluid will result, which will precipitate as soon as morphine is added. (This has already been observed by W. O. Moor.) On testing this precipitate for morphine, negative results are obtained, since the entire amount of alkaloid is oxidised. The same thing occurs in the system, and it seems that the oxidised albumin can pass its oxygen over to the morphine just like the permanganate itself. In all cases of poisoning about half a gramme should be given internally.

The Boards of Education and of Health.

Under the joint auspices of the Board of Education and the Department of Health, a course of lectures on "School Hygiene" to the teachers of the public schools was opened on Oct. 2nd Dr. Matlekovics introduced the course of seven lectures with remarks on the "Nervous Diseases of Children." The lectures to follow Dr. Matlekovics are Drs. Rozsa, Antalfy, and David. All have volunteered their services. The course is in the nature of a preliminary to the establishment of medical inspection of schools.

Operating Theatres.

GREAT NORTHERN HOSPITAL.

Duodenal Ulcer.—Mr. **Peyton Beale** operated on a German, æt. about 25, who had been admitted with the following history:—About two years ago he began to have attacks of vomiting occurring three or four hours after taking food. It seemed that there was some obstruction in the region of the pylorus which caused his stomach to become distended, and when it was fully distended violent vomiting took place, thus completely emptying it; this happened every three or four days. Some years previous to this he had one or two attacks of hæmatemesis and several attacks of melæna. He soon learnt by experience that it was necessary to take food in a fluid state only, and he got on pretty comfortably until about two months prior to his admission, then he began to suffer from severe melæna and very obstinate vomiting, which caused him to become considerably emaciated. Recently he had had two or three attacks of severe hæmatemesis and it was thought advisable to explore his duodenum and stomach. A vertical incision in the mid-abdominal line about four inches in length was made, and on introducing the hand into the abdomen, a thickened mass could be felt on the posterior wall of the duodenum about one inch below the pylorus; this was evidently surrounding an ulcer of long standing, and so firmly adherent was it to the posterior abdominal wall that it was quite impossible to operate on it directly or even to reach the first part of the duodenum at all. The patient's condition was not good, so it was decided to make a communication between the anterior wall of the stomach and a coil of small intestine. A coil of the jejunum was therefore picked up, two openings were made in its mesentery about six inches apart, a strip of gauze passed through each opening and tied once round the bowel, any contents having been squeezed out of the latter with the fingers. An incision about one inch in length was then made on the convex antero-inferior aspect of the stomach, about three inches from the pylorus. The loop of small intestine was then rapidly sutured to the lower edge of this wound. A corresponding incision was next made through the wall of the intestine, and sutures were rapidly passed uniting the opposing cut edges of the stomach and bowel, the remaining inch was closed by external sutures. In all not more than twelve sutures were employed, so that the operation was completed in nine or ten minutes. The area of operation was then quickly flushed out with hot saline solution and the abdominal wall closed, a small gauze drain being left in the wound communicating with the peritoneal cavity. Mr. Beale said it was quite clear that the patient had suffered from perforated duodenal ulcer at some time and the cicatrisation following upon this had bound the first part of the duodenum so firmly to the posterior abdominal wall as to render any operative interference with it impossible; the only plan therefore was to make a free opening from the stomach into the small intestine to prevent the former from becoming again distended. The stomach contents probably trickled slowly over the ulcer through the duodenum, but he believed that the vomiting was the cause of the rupture of vessels which led to the hæmatemesis and melæna; if therefore the vomiting could be stopped by preventing any future distension of the stomach it was probable that the ulcer would cicatrise soundly. His experience in these cases was that a watertight joint in gastro-jejunostomy depended not upon the insertion of a vast number of sutures, but upon the exudation of lymph which takes place very rapidly indeed. If the sutures were inserted very closely together some of them cut through quickly and this disturbed the exudation and was apt to lead to leakage. In all operations of this kind which he had recently performed he had never inserted more than about twelve stitches, and in no case had there been any evidence of leakage. Another very important point was that an operation carried out in this way could be performed in a few minutes and thus a huge amount of shock was easily avoided. Another important point was that many of these patients seemed from general appearance much too ill to stand any operation of the kind; but it was very remarkable how well able they were to stand it, providing it could be performed in ten or twelve minutes. He was in the habit of giving rectal feeds for two days only after the operation, and milk by the stomach on the third day.

A fortnight afterwards the patient was progressing most favourably, and had been taking food by the stomach since the third day after his operation.

TOTTENHAM HOSPITAL.

Operation for Fractured Patella with Absorbable Sutures.—Mr. H. W. Carson operated on a man, æt 28, who had been admitted ten days before for transverse fracture of the right patella caused by muscular action in diving from a spring board. The patient was a fine specimen of a muscular man, and looked younger than his age. A vertical incision was made and the edges of the wound retracted so as to expose the whole patella. The lower fragment was dislocated, so that the fractured surface looked directly forwards; both fractured surfaces were covered with a tough layer of aponeurosis. This was removed with scissors and the joint cleared from blood clots. A double suture of forty-day catgut was passed round the patella through the superficial layers of the aponeurotic expansion beginning from below, passing right round and finishing below like a purse string, special attention being paid to the torn aponeurosis opposite the fracture. The fragments being then held in apposition, the purse-string suture was tightened and the tendinous expansion covering the patella was united with two supplementary catgut sutures, and the skin wound closed with interrupted silkworm-gut sutures without drainage. Mr. Carson said this was the second case in which he had used absorbable sutures in the treatment of fractured patella. He had been led to try this suture because in a former case, where a silver wire had been used, he had been obliged six months after an otherwise successful operation to remove the wire for the relief of irritation and pricking pains; the wire was found quite loose in the firmly united patella and evidently acting merely as a foreign body. With regard to the present case it was evident from the dislocated position of the lower end and the thick layer of tissue covering the fractured surfaces that bony union would have been impossible without an open operation and he considered that the interposition of the aponeurosis between the fragments was the chief objection to treatment of the condition by subcutaneous methods. Owing to the ease of application the operation of suturing by catgut could be done much more speedily than any operation requiring drilling of the fragments, a point of no little importance in the prevention of sepsis in the knee-joint, which, as Mr. Edmund Owen says, "has no margin of error." The supplementary sutures in the tendinous aponeurosis are inserted, he pointed out, to counteract the tendency of the fragments to tilt in such a manner as to cause their anterior edges to separate. The whole operation requires so little manipulation that drainage can be dispensed with. In this case the patient had been kept rather longer than usual before operation, owing to the unusual amount of effusion into the joint, but Mr. Carson did not recommend that operation should be done within a week of the injury in any case, as it was important to allow all acute symptoms to subside. He considered that the displacement in these cases varied according to the extent of laceration of the tendinous expansion on each side opposite the fracture, and he proposes in a suitable case to shorten the operation still further by suturing merely the torn aponeurosis and uniting the tendinous expansion in front of the patella. In his previous case, in which he had used catgut, recovery was uneventful, and although passive movement was delayed owing to fear of putting too great a strain on a suture of unknown strength, movements became free and within a month of operation the patient was walking strongly with full powers of flexion and extension; nine months after operation the patella was firmly united with bony union. Mr. Carson further pointed out the difficulty of sterilising the skin in this region, especially in hospital patients whose skin over the knee is often rough, thick and dirty. He laid particular stress on the importance of not using antiseptic lotions inside the joint because they tend to lower the already feeble resisting power to sepsis of the synovial membrane.

The wound was dressed on the seventh day and found to be healed by primary union. Passive movement was commenced on the ninth day and three weeks after operation the patient was walking about without a limp, and flexion was possible to 60°. The patella was firmly united.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, OCTOBER 11, 1905.

INTERNATIONAL CONGRESS ON TUBERCULOSIS.

The second International Congress on Tuberculosis was opened in Paris on Monday of last week with a large gathering representing most of the civilised countries of the world. The French Government showed a marked sense of the importance of the meeting, for not only did the President of the Republic himself preside at the inaugural ceremony but other ministers were present and all possible assistance was granted to give the Congress a dignity which is so sparingly accorded to public health gatherings in most countries. Nearly three thousand five hundred members joined the Congress, and these being supplemented by some fifteen hundred exhibitors, there was nothing lacking to make the meeting a financial and social success. It is somewhat a pity that into a congress of such size and importance the commercial element should have been introduced in the shape of exhibitions of foods, drugs, and appliances, but perhaps the promoters found this element necessary on the financial side. In a similar way one cannot help thinking that private hospitality to individual members would have been a better form of entertainment than public soirees and crowded receptions. Doubtless the French wished to show all honour to their distinguished guests, but in the few days available for the interchange of views and opinions one cannot help regretting that the scientific side of the Congress should in any way have been encroached upon by society distractions. We imagine that the gathering would have commanded more respect, and its recommendations would have carried more weight, if the time had been given up strictly to scientific pursuits without the intrusion of hospitable junketings. Turning to the immediate objects of the Congress, we find that the work was arranged in four sections, and that an admirable museum of specimens and preparations illustrating the various phases of, and lesions caused by, tuberculosis had been organised. The first section of the Congress dealt with Medical Pathology, the second with Surgical Pathology; the third with the Preservation and Assistance of the Child; and the fourth with the Protection and Treatment of the Adult, together with Social Hygiene. It was hardly to be expected that the bulk of the papers read and speeches delivered would deal with startlingly new and exciting questions, and, indeed, for the most part they seem to have been devoted to the reiteration of the old rather than to the revelation of the new. Still, it is well that the ascertained facts in connection with tuberculosis should be kept constantly to the fore, and as the object of these meetings is quite as much to attract the attention of the laity as to promote the edification of the scientific, the signal value of general sanitary conditions in the prevention of tuberculosis cannot be too emphatically insisted on. To educate people to understand that it is in their hands, and the hands of those whom they choose for their governors that the prevention of tuberculosis lies, is a more important and useful object than even the discovery of a successful method of treating the disease when it is once established. But just as the London Congress provided an unlooked-for sensation so the Paris gathering was not allowed to pass without one. The thunderbolt which Professor Koch hurled into the midst of the tuberculosis world when he informed his audience that bovine and human tubercle were distinct diseases is still fresh in everybody's mind, and probably the greatest benefit of the London Congress was that through the instrumentality of this staggering announcement the English Government were moved to appoint a Royal Commission to study the pathology of tuberculosis *de novo*. Undoubtedly, the sensation of the Paris Congress was Professor von Behring's disclosure, or rather partial disclosure, of his plan for curing tuberculosis. Behring's name, like that of Koch, is an honoured one in the scientific world. The discoverer of anti-diphtheritic serum, like the discoverer of the tubercle bacillus, cannot be treated without the deepest respect, and a pronouncement coming from him is bound to carry weight with any medical audience. What the full details of Behring's method consist in will have to be waited for till next August at least, but in the meantime he has given an outline which is sufficient to indicate the line his researches have followed, and it remains to be seen how far they have led in the direction of a goal which may be regarded as probably the most beneficent that man can reach. If Behring be right, and if his plan be effectual both to prevent and to cure tuberculosis, he will be entitled not only to the gratitude of mankind but to any reward which it is possible for the world to offer. Moreover, if this remedy be indeed a remedy for tuberculosis, it should be capable of standing on its own merits and it should not need the adventitious aid of newspaper paragraphing and popular excitement. The atmosphere of a Congress which, as we have pointed out. is largely, if not in the main, educative, is hardly that most suited to the critical discussion of a method of treatment so technical as Behring's, and we feel that it would have been more prudent and more in accordance with the spirit of the best tradition, if the announcement had been made to a smaller and purely expert audience in an exclusively scientific gathering. Already the Press is vibrating with the stupendous news, and if expectations be not fulfilled we fear that Behring will not only cast a blight over his high and deserved reputation, but that pathological science itself will suffer in the person of a great representative. We also see it stated in reports of interviews which Behring has not very wisely granted to journalists that the discoverer proposes to keep command of his remedy in his own hands and to make private profit out of it. That assertion has been flatly contradicted by Behring himself. He is prepared to give it to the world as freely as all other great scientific discoveries have been given. The true reward of science is to be found in the opinion held of the worker by his fellow-scientists, and not in the applause of the multitude or the balance at his bankers. The remedy, so far as can be gathered from the necessarily imperfect reports that have reached London, is obtained by an analysis of tuberculin into various constituents having various qualities. The therapeutic constituent is isolated and forms the specific remedy. If this be the correct reading it becomes evident that Koch was nearer the great discovery with his tuberculin than has been generally imagined.

THERAPEUTICS OF SEAWATER.

From prehistoric times the value of sea-bathing as a therapeutic measure has been recognised. Even in health it acts as a pleasant and useful tonic, and every one knows the invigorating effect of a swim in the sea. Well-known as is the fact, its explanation is by no means so obvious. As there is practically no absorption of salt water through the skin, the good effects of sea-bathing have been attributed to the action of the waves, the exercise, the fresh air, and the winds, while some hold that an essential part of the benefit derived from sea-bathing is to be attributed to the water that is swallowed. It is more likely, however, that sea-water has certain chemical properties of therapeutic activity, and this suggestion is supported by the known value of sea-bathing in various cutaneous diseases. The nature of these chemical properties has been examined by many investigators, and Legourd in particular has emphasised the importance as an antiseptic of a substance, called by him "hermetin," and said to contain oxygenated compounds of chlorine. Within the last few years, however, therapeutists have not rested content with the external uses of salt water, but have busied themselves in experimenting with it internally. It has been pointed out that the injection of saline solution is a distinct adjuvant in the experimental production of immunity. It is believed that in this case the saline solution aids in the solution of alexins out of the protoplasm of the cells, thereby increasing the protective powers of the body juices. At the same time it probably hastens the secretion of antitoxins, as it has been shown to do in the case of such poisons as strychnine, arsenic and ricin. This protective action of salt solution may go some way to explain the excellent results obtained in France by Simon and Quinton in the treatment of tuberculosis by subcutaneous injections of seawater. The fluid used was Atlantic water, reduced by dilution to isotonism with the blood, and the dosage was one hundred to three hundred cubic centimetres every three or four days. In fifteen out of eighteen cases so treated—most being cases of pulmonary phthisis—there was marked improvement. It is unnecessary to speak of the uses of normal saline solution, as there is hardly a field in medicine or surgery where its value has not been proved. It is to be noted, however, that the meaning of the term "normal saline" is changing from day to day. It is no longer a mere solution of sodium chloride of definite strength, but if it is to approach closely to the physiological body-fluid, it must, as Ringer's solution does, contain small quantities of certain other salts. In fact, the more "normal saline" is defined the more it is seen to approach, in its chemistry, to sea-water, which, indeed, may be regarded as having supplied the protoplasmic fluid to the primitive cell-life of our earliest ancestors.

CYTODIAGNOSIS.

MEDICINE, above all other arts, is happy in commanding the whole-hearted services of a bevy of handmaids in the shape of a number of subordinate or associated sciences. Those who practise medicine, however, have often to possess their souls with patience for many a year before it is possible to assess fresh advances in the sub-sciences at their precise value in the field of medical work. For instance, a quarter of a century after the discovery of the tubercle bacillus we have yet to devise effectual methods both to prevent and to cure tuberculosis. Yet already the incidence of the disease has been greatly checked, and if treated in the earlier stages it may be classed among the curable maladies. It is significant, however, that cure has hitherto been encompassed by attention to the environment of the patient so as to increase his powers of resistance rather than by any remedy arising directly out of our knowledge of the specific pathogenic bacillus that lies at the root of the mischief. For all that, diagnosis, especially in obscure cases, has been greatly extended and strengthened by the use of injections of tuberculin. Here, again, the presence of tuberculosis in a given case is recognised by the temperature and the physical signs following the administration of the test drug. As regards primary tuberculous pleurisy, the diagnosis is extremely difficult, or, indeed, impossible, under ordinary conditions. We know that a certain proportion of cases are of tuberculous origin, and it is of the utmost importance in the interests of the patient to ascertain the precise origin of the attack. An examination of the effusion, either directly by means of stained films, or indirectly by cultures or by inoculation, fails to yield any positive evidence in the vast majority of cases of tuberculous origin. It is therefore a matter of considerable practical interest to learn that the ultimate course of the effusion may be ascertained with accuracy by another method, named "Cytodiagnosis." In our last issue (October 4th), an article was published dealing with the subject, written by Dr. J. Odery Symes, of Bristol, a physician who has done some of the best work hitherto achieved in that particular direction. The main causes of origin of pleuritic effusions may be described as mechanical, tuberculous, pyogenic or infective, and malignant. Dr. Symes' conclusions may be summed up as follows with regard to the distinctions between the various fluids associated with those conditions :—"In tuberculous effusions the lymphocytes predominate ; in effusions due to other micro-organisms, there is a high percentage of polymorphonuclear leucocytes ; in mechanical transudation large numbers of endothelial cells are found ; and in cancer of the pleura certain cells characteristic of the new growth are to be detected." The result, so far as concerned the tuberculous effusion, was drawn from five cases of primary tuberculous pleuritis. In one case the diagnosis was confirmed by the discovery of tubercle bacilli in the fluid ; two cases reacted typically to tuberculin ; and the remaining two were attested by the clinical diagnosis of the medical attendants. The average lymphocytes were 94 per cent., and polymorphoneuclocytes 3 per cent., as against 41 per cent. lymphocytes and 50 per cent. polymorphoneuclocytes in six cases of infective pleurisy. There is no need in this place to enter into further details of the method whereby a special diagnosis of the kind here discussed may be made from an examination of a stained film under the microscope. The main point is to draw attention to the fact that it is now possible to form an accurate diagnosis in cases of inflammatory effusion, where previous methods would have presented us with tentative probabilities. Cytodiagnosis can be applied with equal ease and certainty to other effusions, such as those of ascitic, of hydrocele, and of cerebro-spinal origin. In cerebro-spinal fluid, for example, the presence of appreciable numbers of polymorphonuclears is an indication of acute meningitis from such organisms as the pneumococcus, streptococcus, or diplococcus. This contribution of Dr. Symes constitutes an important step towards reducing the advanced science of blood and blood derivatives to an everyday value. The plain easy chart of blood investigations has yet to be written, for that branch of study is now apparently choked by a growth of barbarous names and of highly technical methods that make it caviare to all but the expert in blood. It is to be hoped that someone will do for the wider study what Dr. Symes has achieved in the subsidiary section of inflammatory effusions.

Notes on Current Topics.

Illicit Liquor Traffic.

MANY and grave as are the evils inflicted by the patent medicine trade on the health of the people of this country, it is to a large extent spared an insidious fraud which is rife in America. There it seems that a large proportion of preparations which are advertised and sold as patent medicines consist of whisky and other forms of alcohol, and that to give the spirit the appearance of medicine small quantities of tasteless drugs are added. In this way secret drinking by women is largely promoted, as, under the pretence of buying medicines, they are able to lay in stocks of their favourite spirit without incurring suspicion. Fortunately the Commissioner of Inland Revenue, with a perspicacity which our own Commissioners would in some ways do well to imitate, has decided to control this flagrant abuse by ordering that all dealers of intoxicating preparations masquerading as medicines must take out spirit licences, and that druggists supplying such preparations must take out retail liquor licences. The nostrum manufacturers are up in arms and highly indignant at the exposure which this regulation will bring on their methods of doing business, for it has been in the prohibitionist states that their trade has chiefly flourished, and in them it will be seriously curtailed. In America, where trade influences are particularly strong, all suggested reforms in the patent medicine business are nullified by the influence of the newspapers, which there, as here, depend largely on these advertisements for their profits. It is satisfactory to note that this important reform has been brought about to a great extent by the medical journals.

The Pathology of Clothes.

A witty writer has contributed to *St. George's Hospital Gazette* a prospectus of a proposed work on the pathology and treatment of diseases and accidents of the toilet. The prospectus is fortified by alleged extracts from the forthcoming volume, which for pure fun and cleverness of caricature are unrivalled. Among the lesions described are "perforating ulcer of the sock," "false passages of the vest," "hairy mole of the shirt-cuff," "idiopathic atrophy of the pyjamas," "sloughing of the posterior foramen of the collar-band," and "prolapsus trouseri," while a further chapter is said to be devoted to affections peculiar to evening dress, such as "Addison's disease of the shirt-front," "madura pump," and "inoperable volvulus of the neck-tie." The causation of false passage of the vest is described thus :—"The head, being hurriedly thrust into the garment, lacerates the fabric, and emerges through the posterior wall of the axilla instead of through the cervical canal." "The best treatment is prolonged rest in bed." With regard to perforating ulcer of the sock, "treatment by simple suture or the purse-string ligature is not to be recommended. Each perforation must be carefully grafted by an expert." We hear much nowadays of the overworked condition of the medical student, so that we can all the more admire the energy and research of this writer in treating a hitherto unbroken field.

Death From a Wasp-sting.

A tragic and interesting occurrence was investigated by the Sussex coroner last month. A woman, the wife of a working-man, was drinking a glass of stout, when she felt a sudden pain in the throat in connection with a solid body that had entered her mouth in the liquid. She coughed the body out and found that it was a wasp. Beyond natural fright and some discomfort in the throat, she seemed but little the worse for her experience, and for the next few days she was comparatively well, so that medical assistance was not sought. Then she felt rather faint and out-of-sorts, but continued to pursue her ordinary avocations till the sixth day after the sting, when she was so unwell as to have to call in a doctor. The medical man examined her, but he found little evidence of serious illness, and was inclined to regard the condition as not being of much consequence. But the symptoms rapidly increased and took on a grave character. Cellulitis of the throat and nasal passages developed, and death from septicæmia followed in two days. Dangerous as wasp-stings occasionally prove themselves to be, serious symptoms in such cases usually come on rapidly, but in this case there were some days of normal health intervening, and when the illness assumed a severe turn the malady showed the characteristics of a spreading cellulitis, and not those of a toxæmia. This country is fortunately free from the more virulent wasps that are to be found on the American Continent, but the case under notice shows that the indigenous insects are capable of producing dangerous wounds in more ways than one.

Ambulance Service in New York.

It is doubtful if there is any city of importance in the civilised world so behindhand in ambulance requirements as London. Most of the provincial cities are far ahead of it, and it is with a curious sense of inferiority that one finds that the ambulance service of New York—admirable as it appears to us, in comparison with what we have been used to—is yet regarded with great discontent by our contemporaries in America. In New York, ambulances are the property of and are kept at the various hospitals, and in case of accident or street illness. the police official telephones to the hospital he thinks nearest. On the arrival of the ambulance the surgeon accompanying it examines the patient, and if he regards the case as trifling or unsuitable for hospital treatment he gives what aid he thinks fit and departs. Under such conditions it is natural that mistakes sometimes occur, and their unnecessary frequency of late has given rise to much public comment. It is difficult, in a hasty examination on the pavement of a crowded street, or on the floor of a drug-shop, to make a diagnosis with accuracy, but it is better to err to the graver opinion than to reject as drunkenness or hysteria what may be cerebral hæmorrhage, or some other serious condition. It is suggested as an improvement on the present state of affairs that ambulances should be maintained at convenient centres by the city, so that there should be no delay in bringing patients to hospital, and that there should be a regular system by which the aid of neighbouring physicians might be sought and their service remunerated in the less serious cases.

Ada Lewis Nurses.

Mrs. Lewis-Hill, better known to the world as Ada Lewis, widow of the well-known citizen, Sam Lewis. has founded an institute which is worthy of the highest commendation. This institute aims at supplying nurses to the poorer middle classes in time of sickness, and to prevent abuse and to mark the difference between her nurses and those supplied to the poor, a fee of a few shillings a week is to be charged for their services. The Ada Lewis Nurses' Institute is to be opened on the 26th of this month at 62, Oxford Terrace, W., and we venture to characterise the scheme as one of the most useful, enlightened, and beneficent that we have heard of for a long time. It is to be a condition of employment that no nurse is to act except under the direction of the patient's own doctor, a regulation which will be approved of by those who have had experience of the "prescribing" nurse. A strong recommendation of the scheme lies in the fact that general practitioners will be able to perform many of the minor operations or to conduct methods of modern manipulative treatment in the home of the patients, who now have to go to hospitals because they cannot afford to pay for a nurse. Above all, it will bring to one of the most deserving classes in the country the benefit of a care and a relief which are now confined to the rich and the very poor—a benefit which will not compromise their independence or make them feel that they are taking charity. We warmly congratulate Mrs. Lewis-Hill on her idea and her good-heartedness, and we wish the scheme the full measure of success that it deserves.

Tetanus and Patriotism.

Our contemporary, the *Journal of the American Medical Association*, in a recent number, has published its annual summary of the statistics of injuries arising from the Fourth of July celebrations. It is satisfactory to note that the improvement in the tetanus returns noted last year has been maintained, the number of cases for the past three years being respectively 1903, 415; 1904, 105; 1905, 104. Of the 104 cases of tetanus, 87 ended fatally. The improvement shown since 1903 is attributed to the increased restrictions placed by various cities on the use of explosives, and the absolute prohibition in many of the use of the toy pistol. Apart from tetanus, there were 95 other deaths, and a total of 4,994 non-fatal injuries. These injuries were in many cases of a serious nature, such as loss of an eye, a limb, or one or more fingers. There were 23 persons burnt to death by fire resulting from fireworks, and ten persons died from shock or fright due to sudden loud noises near them. That all this fearful holocaust could have been easily avoided may be learnt from the lesson of Baltimore. That city, having entirely prohibited the use of fireworks, this year shows a practically clean sheet as regards accidents on the Fourth.

An Apostle of the Simple Life.

It is not often that fashionable fads commend themselves so favourably to medical opinion as does the cult of the "simple life." Foolish as are many of its manifestations the principle underlying them is sound. There is no doubt that many of the diseases from which modern society suffers most are in nature and in source diseases of civilisation. We have to pay in health and human life a heavy debt for the benefits of civilisation, and the question raised by the followers of the "simple life" is whether all the items of the debt are justly due. Pneumonia and tubercle are in great part the result of our indoor life, and it is perhaps possible to avoid them by a policy of open-air. Similarly, it may be possible to avoid dyspepsia by the use of simple and more wholesome diet, and so in other cases. It is nevertheless curious to reflect that one of the earlier apostles of the "simple life," Henry David Thoreau, himself fell a victim to tubercle. If anyone lived a simple life it was Thoreau. In his shanty at *Walden* he lived like the wild animals who were his sole friends. His food was berries and nuts, his drink the water of the stream, his pillow as often as not the pine-tree root. A weakling in childhood, he developed an extraordinary physical strength, and could outstrip any of his neighbours in walking, running, rowing and swimming. Nevertheless, he allowed himself to be infected with tuberculosis, and his great physical strength and health did not save him from a comparatively early death. There is little doubt too, that it was in his woodland hut he contracted the disease, for, to his honour be it said, his hut was one of the "stations" on the great "underground railway," by means of which so many slaves gained freedom under the English flag. Many of them, unfortunately, were victims of phthisis, and the "stations" were, in consequence, regular hotbeds of infection.

Bells or Barbarism.

A storm has been raised in the Fulham tea-cup by a recent application of a Putney resident for an injunction to silence the peal of bells which has long been the pride of the old parish church. For nearly two centuries the Fulham bells have rung the changes, their chimes more than once greeting the ears of royal personages on their river-passage to the ancient palace at Hampton Court. The worthy individual, however, to whom their notes were little short of torture, even at the distance of half a mile, is not alone in his experience, for other residents of the district have openly declared them to be a nuisance, if not "a relic of barbarism." There are probably few people who have not, at some time or another, been greatly disturbed by the ringing of church bells, especially when their tone is the reverse of musical. Some people, it is true, are absolutely unaffected by a monotonous clang, oft-repeated, and only become conscious of the sound when their attention is drawn to it. To such the subject has no interest, but to sensitive souls who remain indoors the advent of Sunday or practice-time is an ordeal indeed, if they live too near to a church where bell-ringing is treated as a fine art. A state of nervous irritation is set up from which there seems no escape, the monotonous rhythm is maddening, while a single bell offends a hundredfold. To accustom oneself to neglect the sound—the usual advice of the unsympathetic unmusical person— is a sheer impossibility, as the victim knows only too well. Perhaps, if objectors were to turn bell-ringers we should hear fewer complaints, for the exercise is really most beneficial for the heart and lungs. Indeed, we may expect to see the ringing of so many peals *per diem* solemnly recommended by the faculty as a prescription for neurasthenia!

The Puff Collateral.

The author of *The Critic* has given us a classification of the various modes which the Puff may assume, and it is sufficiently comprehensive to serve for all time. The Puff direct we are all familiar with from the advertisement columns of the periodic press, and scarcely less so with the Puff preliminary and the Puff oblique. The more invidious puff by implication and puff collusive are not infrequently met with, but we are furnished with fine examples of that rarer variety, the Puff collateral, by the *Liverpool Daily Post* of the 27th of last month. In it we read that Liverpool is regarded as a kind of Mecca by medical men all the world over, and when they wish to perfect themselves in modern specialities, it is to Liverpool they resort. We have nothing but admiration for the Liverpool schools of medicine, but it comes as a surprise to us that the advent of an American surgeon to study their methods should excite the press of the northern city to such a pitch of self-satisfaction as is exhibited in the article before us. It appears that Dr. Joel Goldthwait, of Boston, having arrived at Liverpool, the Southern Hospital has gained a "feather in its cap" by Dr. Goldthwait's decision to study in its walls. But it is not so much the Southern Hospital as one of its surgeons, an "eminent bone specialist," that is the object of Dr. Goldthwait's attentions, so that the real lustre of the visit falls not so much on Liverpool generally, and the Southern Hospital in particular, as on the surgeon in question. That gentleman may be absolutely acquitted of any share in a puff which is probably more distasteful to him than to the profession at large, but really the *Liverpool Daily Post* must be hard up for news if this is the sort of stuff it has to dress up for its readers.

Unscheduled "Spirits of Salts."

British Law is full of anomalies, and it seems to be a feature of our national character to put up with absurd defects for generations or, it may be, even for centuries before they are remedied. Politicians are wont to speak of the "education of the people" in this or that matter, especially when they wish to excuse their party from taking definite steps in this or that direction. "Public opinion is not ripe upon the subject," they say; "it has still to be educated to the proper pitch." Turning to the facts of daily life, it may be asked if public opinion is not yet ripe upon the advisability of adding hydrochloric acid, or spirits of salts, as it is known to the man-in-the-street, to the schedule of poisons. A few weeks ago the Coroner for the City of London held an inquest upon the body of an unfortunate woman who had drunk the acid out of an ordinary public-house spirit bottle, mistaking it for gin. That is an old, old story, which has been poured into the ears of coroners' juries for many generations past; in fact, ever since hydrochloric acid was invented. In a certain sense it would be better if Government devoted less time to over-sea matters and more to such everyday domestic details as the sale of poisons and the thousand-and-one facts of environment that fall naturally under the control of local sanitary authorities.

Aseptic Fighting.

The fine degree to which the Japanese carry the science of preventive medicine into the science of war was strikingly illustrated in a speech made by Surgeon-General Suzuki at the Convention of Military Surgeons at Detroit on September 27th. Surgeon-General Suzuki told his audience that when a naval battle was anticipated every member of the crew of the Japanese man-of-war were made to bathe and to dress in perfectly clean underclothing, so that should they be hit by a projectile the skin around the wound and any clothing that was carried into the tissues would be as free from micro-organisms as possible. To these precautions he attributed much of the success that had attended the treatment of wounds, and probably not without justification. Moreover, a solution of boric acid was supplied to the men to enable them to wash out their eyes when affected by smoke and dust, and cotton-wool was given them so that they might plug the ears to prevent rupture of the tympanum from concussion caused by the guns. Such precautions strike the members of the Old World as being as admirable in theory as they have been found in practice, but do they not suggest that aseptic methods could be carried further? We can imagine a Geneva Convention of 1950 or thereabouts laying it down as a rule of humanitarian warfare that the members of both hostile forces should sterilise their swords and bayonets before going into action, and making it an offence against international law for combatants to spit on the battle-field. The day when public opinion approves anything of the kind will be a happy one, for it will mark the beginning of the abolition of the absurd anachronism of war between civilised nations.

Resident Medical Officers and Coroner's Fees.

The fact that the resident medical officers of voluntary medical charities are not entitled to receive fees for evidence given at an inquest constitutes a strikingly unjust anomaly. It forms an exaggerated instance of the way in which important services are exacted from the medical profession without recompense. There is no conceivable reason, so far as appears on the surface, why a medical man should not receive a guinea for his evidence simply because he happens to dwell within the four walls of a hospital. It is to be hoped that the attention of Parliament will be drawn emphatically to this injustice by some of our professional brethren in the House of Commons. But, glaring as the abuse undoubtedly is, it is repeated and amplified in many or most of the Poor-law infirmaries of the United Kingdom. In these institutions the medical officer is entitled to demand fees, but the guardians, in order to save the rate-payers' pockets, in most cases make it a condition of appointment that the applicant must forego such fees. The condition is absolutely illegal, and it is simply owing to the disorganised state of the profession and the helpless apathy of the General Medical Council and other representative bodies that it is permitted to continue. If Lord Lister would bring the matter before the House of Lords he would be laying the medical profession under a great obligation.

The Toronto Meeting of the British Medical Association.

The British Medical Association having accepted the invitation to hold the next annual meeting in Toronto, Canada, the profession of Canada have unanimously nominated Dr. R. A. Reeve, of Toronto, as president, Drs. Mackenzie and Wishart local secretaries, and Dr. J. F. W. Ross treasurer. The meeting will be held in August. Dr. Charles O'Reilly, well known on account of his long connection with the Toronto General Hospital (having just retired from the position of Medical Superintendent, after a continuous service of thirty years), who is at present spending a week in Dublin, has asked us to assure his Irish confreres of the warm welcome the Canadian profession will extend to all members across the sea who attend the first meeting of the Association in the Dominion of Canada. Dr. O'Reilly is vice-president of the Hospital Association of the United States and Canada, the largest and most important Association of the kind in the world, having for its aim and object the improvement of all hospital work, with a due regard to educational facilities in connection with clinical teaching. Toronto, which covers 17 square miles, is situated at the head of Lake Ontario, and has a population of 230,000, over 400 medical men, over 600 medical students in Toronto University, and six hospitals. It is the educational centre of the Province of Ontario. In 1904 the births were 5,283, the deaths 3,886. The total assessment of taxable property is over thirty million pounds. The hotels of Toronto are large and up-to-date. Dr. O'Reilly tells us that the most liberal terms will be arranged for in the way of transportation across the Atlantic, and for trips over Canada after the meeting is over.

Semi-Teetotalism.

Semi-teetotalism is a barbarous name for what really seems to be a very good object. The out-and-out teetotaler, though an excellent person in many ways, has long ceased to be a "temperance man," and by his intemperate advocacy has often estranged many who bore his cause good will. Probably the *pukka* teetotaler will look rather aslant at his half-cousin who proposes to dally with the "evil thing" to the extent of taking a glass of beer with his lunch and a little wine with his dinner. But really the semi-teetotaler seems, from the medical point of view, to be a very sensible fellow, for he binds himself and those who enter into pledge with him to take none of those insidious inter-prandial potations which at the present day constitute the real danger of drinking alcohol. A meeting of the "Semi-teetotal pledge movement" is to be held at the Mansion House on Ocotber 24th, with the Lord Mayor in the chair and representatives of the Army, Church, and Bar around him. Although we do not notice the name of any medical man in the announcement of the speakers, we feel sure that the semi-teetotalers will find many supporters within the ranks of the profession. Alcohol taken with meals cheers and seldom inebriates; taken between them, it frequently does the reverse. But would it not be well for the semi-teetotal pledge movement to define when a meal ends and the forbidden drinking begins? It is possible to sit over the nuts and wine, as our grandfathers used to, till the diners have lost touch with their equilibrium, and yet it would be difficult to say that the semi-teetotal pledge had been infringed? The danger we see ahead of the semi-teetotalers is this difficulty of definition, and if a semi-teetotaler becomes a demi-drunkard the success of the movement will be liable to be compromised.

The Central Midwives Board and the Belfast Hospitals.

On Thursday last, the Central Midwives Board had again before it the case of the Belfast Maternity Hospital, to which reference has been made already in our columns. Mr. Ward Cousins had with commendable pertinacity given notice of a fresh attempt to bring the Board to a sense of the duty it owes to the public in general and to institutions such as the Belfast Hospital in particular. What might have been the result of his effort it is impossible to say, but we believe that had the Belfast maternity authorities been content to trust to him and to risk even another temporary repulse they were bound eventually to establish their case. Unfortunately, it appears that they considered it was better to effect a compromise, and accordingly they submitted a fresh proposal to the effect that pupil nurses who had applied to the Board for recognition before April 1st of the present year should be put upon the register, not as *bona-fide* nurses, but as Belfast Maternity Hospital pupils. This compromise was accepted by the majority of the Board who have opposed the Belfast demands so far, and was used as a lever to overthrow Sir William Sinclair's and Mr. Ward Cousins' proposal for the recognition of the hospital certificate and of nurses already trained. The effect of the decision will apparently be to establish a class of nurses never contemplated by the Act, and to leave out in the cold those nurses who waited for their hospital certificates to be recognised before individually applying to the Board. If any of these unfortunate women practise nursing in England, they will cease to be midwives in 1910. We think, as we have said, that the Belfast authorities were just a little too hasty. The action of the Central Midwives Board through this whole case has been very similar to its action in the case of the Dublin Hospitals. The cup of ineptitude and partiality, which the Board has been so persevering in its efforts to fill, is nearly overflowing. A little more and the Board by its own actions will have demonstrated, even to its supporters, that the time has come to prune and refashion it beyond recognition. We understand that there is a danger that one of the few capable members of the Board may soon cease to hold office. Sir William Sinclair's term of office will expire at the end of October, and we fear that, wearied by his efforts to introduce commonsense and a sense of responsibility into the conduct of the affairs of the Board, he may not desire re-election. We hope, however, that his sense of duty will induce him to remain at his post, and, if he decides to do so, we are confident that the Lord President of the Council, whose nominee he is, will re-appoint him. We wish it were as certain that the Lord President in the exercise of his discretion would also select, as his second nominee, a person who could be equally trusted to add to the capacity and reputation of the Board. The Midwives' Institute already possesses a representative on the Board, and it is unnecessary that it should indirectly possess another. We have little doubt that, if the Lord President, as an Irishman, could be shown the manner in which the majority of the Council have acted towards the legitimate rights of Irish Hospitals and Irish trained midwives, he would ensure that his nominees at least could be trusted to act fairly. If his Lordship desires to appoint a woman, there are surely many women doctors from whom he could select, and who are in a position to understand what are the essentials which must be possessed by a training institution and by a midwife, to entitle the one and the other to recognition by a state-constituted board.

PERSONAL.

THE Rev. Dr. Headlam, Principal of King's College, London, will preach at the annual service of the Guild of St Luke at St. Paul's on Thursday, October 19th, at 7.30 p.m. The choir will be provided by the London Church Choir Association.

SIR WILLIAM SMYLY and Sir Thornley Stoker have been nominated by the Royal College of Physicians of Ireland and the Royal Academy of Medicine respectively to represent these bodies on the Executive Committee appointed to arrange for the forthcoming visit of the British Association to Dublin in 1907.

PROFESSOR E. J. McWEENEY has represented the Dublin Branch of the National Association for the Prevention of Tuberculosis at the International Congress on Tuberculosis.

A NEW hospital for Infectious Diseases was opened recently by the Duke of Northumberland at Newburn. The buildings accommodate 28 beds, and the cost was £7,964.

THE American Ambassador will perform the opening ceremony at a grand American bazaar to be held in the Town Hall, Stratford, on October 26th, 27th, and 28th, in aid of the West Ham and East London Hospital.

DR. NAYLOR BARLOW, the medical officer of health for Bootle, has been elected president of the North-Western Branch of the Incorporated Society of Medical Officers of Health.

MR. A. K. PECK, Assistant District Officer, Kuala Pilah, Federated Malay States, has left for England on twelve months' leave of absence.

SEVERAL changes have been made in the Medical Department of the Straits Settlements. Dr. S. H. R. Lucy becomes Colonial Surgeon, Penang, and Dr. W. S. Sheppard, Colonial Surgeon, North Province, Wellesley.

DR. M. J. WRIGHT, State Surgeon, of Perak, Federated Malay States, has been nominated by the Resident General to represent the Government of the Federated Malay States on the Council of the States and Federated Malay States Government Medical School.

DR. D. K. McDOWELL, C.M.G., Principal Civil Medical Officer of the Straits Settlements, has been selected for the office of Inspector-General of the Medical Service and Medical Institutions of the Federated Malay States.

THE annual dinner of the Bristol Medical School will be held on October 26th, at the Royal Hotel, College Green, Bristol, when William Osler, M.D., F.R.S., LL.D.Edin., the Regius Professor of Medicine, University of Oxford, will be the guest of the evening, and Professor R. W. Done, of Oxford University, will preside.

THE next Tuberculosis Congress will probably accept the invitation from Mr. Roosevelt communicated by the American delegates to the bureau of the Congress, to hold the next congress in the United States.

THE new College of Hygiene and Physical Training instituted by the Carnegie Dunfermline trustees was formally opened last week by Lord Linlithgow, Secretary for Scotland, and vice-president of the Council of Education in Scotland. The opening ceremony took place in the gymnasium, and was attended by between 600 and 700 ladies and gentlemen. The chair was occupied by Dr. John Ross, chairman of the Carnegie Dunfermline Trust.

FLEET-SURGEON J. LLOYD THOMAS, R.N., who for some time has been principal medical officer at Whale Island, otherwise H.M.S. *Excellent*, the chief naval gunnery establishment, has been appointed to H.M.S. *Victory* for "special service" as a member of a "congress of military surgeons of the United States at Detroit, and to represent the medical department of the Admiralty on that occasion."

SIR LAUDER BRUNTON, F.R.S., delivered the opening sessional address of the Medical Society of London on Monday last, as the incoming President.

Special Correspondence

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

OPENING OF NEW COLLEGE OF PHYSICAL CULTURE.—This college, which has for its object the teaching of physical culture and hygiene, has recently been opened at Dunfermline by the Marquis of Linlithgow, Secretary for Scotland. The idea is to give the students a thorough training in everything connected with the teaching of health culture and of the advantages of hygiene and sanitation to the welfare of the body. In a few years this college will be able to send out into all parts of the country men and women suitably equipped to teach these subjects to children, and if the schoolmasters and the parents of the children will co-operate with these teachers, then there is no doubt that the college will be the means of helping the rising generation to attain better health, and thus increase the power, influence, and well-being of the whole country. Whether the people of this country, taking into account the spread of education and the more enlightened views regarding sanitation and hygiene, are to-day in a worse state physically than in the days when a more open-air life was lived, but without any of the advantages of these recent times, is a question much discussed and upon which opinions differ widely, and at the opening of the college this question was touched upon. However, whether the physique of the people has degenerated or not is now beside the mark; the thing to be done is to try and improve matters in this connection, and the foundation of this college is a step in the right direction.

Northern Medical Society, Glasgow —The first meeting for the coming session of the above, which is the youngest medical society in Glasgow, was held on Tuesday, the 3rd inst., in one of the rooms at the Art Institute, when the undernoted office-bearers were, elected:—President, Dr. John Ritchie; vice-presidents, Dr. J. A. G. Macewen and Dr. MacBryde; treasurer, Dr. Scott Frew; sealkeeper, Dr. Inglis; auditors, Dr. Edmiston and Dr. Malcolm Campbell; council, Dr. Miller, Dr. William, Ritchie, Dr. Ballantyne, Dr. A. T. Campbell, Dr. C. S. Marshall, Dr. J. S. Muir, Dr. Stewart, Dr. J. W. Allan, Dr. J. G. Gray, Dr. A. G. Hay, Dr. Baird, and Dr. Syme.

Southern Medical Society, Glasgow.—The first meeting of this society for Session, 1905-6, was held on Thursday evening, the 5th inst., in the Medical Club, when the president, Professor Stockman, delivered the presidential address on the subject of "Heredity in Disease." It occupied fully an hour in delivery, and was a most exhaustive and carefully reasoned out address, which was listened to by an unusually large number of members. On the motion of Dr. Napier, a very hearty vote of thanks was accorded Professor Stockman for his very thoughtful and instructive address. Then followed the election of a representative for the Board of Governors of the Victoria Infirmary. Dr. Charles E. Robertson has held this much-prized office for a number of years—six or seven—and it is generally acknowledged that he has discharged the duties very efficiently. Last year, however, it was thought that such an office should go round, and therefore Mr. Thomas Richmond was brought forward against Dr. Robertson. The result of the ballot in a large meeting on that occasion was in favour of Dr. Robertson by one vote. This year, again, Dr. R. W. Forrest, Sen., was balloted against Dr. Robertson, the result being that Dr. Robertson had twenty-three votes, Dr. Forrest, twenty-one votes. We understand that the Council of the Society have under consideration the question of limiting the tenure of this office. At present the appointment is made annually. The members of the Society dine together on the evening of Thursday, the 19th inst., in the Grosvenor Restaurant. Sir William Taylor, Hon. President, is expected to be present.

Successful Inebriates' Home at Greenock.—The Inspector of Homes for Inebriates for Scotland gave recently a very favourable report as to the usefulness of the above institution. It has proved of great benefit to the town, and is doing work worthy of the support which it has received. It has been well managed, and the expenses have been kept low, each inmate costing an average of 1s. 11d. a week for his maintenance.

BELFAST.

Medical Graduates and the Queen's College Better Equipment Fund.—A meeting of medical graduates was held in the Medical Institute, Belfast, on Thursday last, in support of the movement to raise £20,000 for the better equipment of Queen's College, a like sum being promised by Sir Donald Currie on condition that this is obtained, as already noted in this column. The chair was taken by Dr. Calwell, President of the Ulster Medical Society, who, in a few words, explained the object of the meeting. Dr. J. R. Davison moved the first resolution: "That this meeting of the medical *alumni* of Queen's College, Belfast, expresses its appreciation of Sir Donald Currie's munificent offer, and that it declares its intention to assist the Committee of the Better Equipment Fund in its efforts to secure the full benefits of the proposed gift." In a short but excellent speech, Dr. Davison explained something of what this fund had already done for the college, and what it was proposed to do in the future in various departments. He was authorised to state that it was not proposed to spend any part of the fund on bricks and mortar, but to use it specially to provide assistants in various departments, and that such assistants should as far as possible be young *alumni* of the College, who might wish to pursue special courses of study. They would be a class of men something like the *privat docents* of the German universities, and one could see what an advantage to the college such would be. A committee was formed, and Sir Wm. Whitla, Dr. McKisack, Dr. J. R. Davison, and Dr. T. Houston were appointed secretaries. Over £1,100 has already been subscribed by the medical graduates, the subscriptions including sums of £200 each from Sir Wm. Whitla and Professor Redfern, £100 each from Professors Sinclair, Lindsay, Byers, Milroy, Symington, and Drs. Wm. Graham and J. St. Clair Boyd, and £50 each from Drs. A. B. Mitchell, Kirk, McKisack, Cecil Shaw, J. R. Davison, and Calwell; £25 each from Drs. Colville and Gardner Robb, and a large number of smaller subscriptions. The first general list of subscriptions to the fund was published on the 7th inst., and amounts to £12,554 so that the prospect of collecting the required £20,000 by Christmas is decidedly encouraging.

Special Articles.

THE LONDON MEDICAL EXHIBITION.

From Monday, October 2nd, to Friday, October 6th, a medical exhibition was held in the Royal Horticultural Hall, Vincent Square, Westminster, organised by the proprietors of the well-known journal *The British and Colonial Druggist*, who may be congratulated upon having made a striking success of the whole undertaking. Admission was between the hours of 2 p.m. and 10 p.m., and the comfort of visitors was looked after in every way, including a reception room, light refreshments and an excellent band. Invitations were issued only to medical men, who responded to the extent of some two thousand. This wise curtailment of the invitation list enabled those for whom a show of this kind is primarily intended to examine the various exhibits with comfort and with plenty of opportunity for leisurely and complete inspection. As regards the quality of the show, it may be stated briefly that the result, in spite of the absence of several well-known firms, was thoroughly representative of modern advances not only in every branch of medical and surgical art, but also in their more or less remote accessories. Coming from the reception room, the first stall to attract attention was that of Messrs. Duncan, Flockhart and Co., of Edinburgh and London, who made a prominent show of their ethyl chloride inhaler, a business-like appliance for the introduction of which the firm deserves every credit. The amount of space at our disposal will not permit of any minute detail of the contents of the stalls of the ninety-four exhibitors. Messrs. Newbery and Sons had a good exhibit of new preparations well worthy of careful investigation. Messrs. Burgoyne, Burbidge and Co. had a most interesting collection among which may be noted calomelol, a substitute for ordinary calomel; another product was collargol (Heyden's), sold in tablet form for antiseptic purposes; they also showed chloroform for seasickness, and a cheap Japanese water-bottle of oiled paper for the local application of hot and cold water. Messrs. Southall and Barclay (of Birmingham) were in evidence with their sanitary towels. Their chief novelty was "Lofotol," a combination of cod-liver oil and carbonic acid gas for which special therapeutical advantages are claimed. Jeyes' Sanitary Compounds Co. made a great show of their powerful non-poisonous antiseptic Cyllin, which is prepared in various forms, as solution, ointment, lozenges and so on. Medical men would do well to give these preparations a trial. One of the largest and most up-to-date stalls was that of Messrs. Parke, Davis and Co. We particularly noticed a throat and nasal spray with a wide nozzle, made of glass so that it can be boiled. This is one of the best articles of the kind we have seen and should command a very wide sale. The same firm has a fine morocco-covered tin case for first aid in motors and on yachts. It is fitted with every requisite and is called the "Yachtmobile." Another most excellent article is a perfectly fitted metal poison emergenoy case, containing a saline infusion apparatus. This firm also showed a lime-light demonstration of their serum farms and laboratories in America, where the production of therapeutic serum is conducted on a Gargantuan scale. Mr. William Martindale had a useful show, including urinary cabinets and capillary tubes for preserving and administering single drops of eye-solutions. Messrs. Thos. Christy and Co. had a remarkably full show, amongst which Dioxogen was prominent, a chemically pure solution of peroxide of hydrogen. One excellent exhibit was a portable pocket lamp and battery fitted with tongue depressor and mirror. The mineral waters of Messrs. Ingram and Royle are so well known that there is no need here to do more than mention the name, and at the same time to draw attention to their latest production, Vittel water. The Angier Chemical Co. showed their emulsion of petroleum with hypophosphites and a number of throat tablets of various kinds. Messrs. Maw, Son & Sons had an extensive and fascinating show of medical and surgical instruments and appliances. Their comprehensive exhibit included modern productions of every conceivable kind, and a whole evening could have been profitably spent in a careful survey of its many attractions. Messrs. Arthur Cox and Co. (Brighton) had an attractive stall, showing the pearl-coated pills for which they are famous. They also had a citrate of lithia tablet which disintegrated readily in water and seemed a perfect thing of its kind. Messrs. Armour and Co. (London and Chicago) showed an essence of pepsin, each ounce containing a drachm of their standard pepsin, and a glycerin extract of red marrow. Soluble beef and other meat preparations were also naturally prominent. They also showed various suprarenal products. Messrs. Fairchild Bros. and Foster exhibit their peptogenic milk powder and other well-known peptonic preparations. Mr. G. H. Zeal (London) showed his most ingenious "Repello" thermometer, an instrument that for convenience and rapidity deserves a wide popularity among medical men. Mr. George Bach drew a good deal of attention to his diabetic whisky, an excellent sugar-free spirit of pleasant flavour. Messrs. Knoll and Co. had a well-arranged display of their various chemical preparations, and we also noticed our old friends Bovril and Virol were again to the front. Among other well-known names may be mentioned those of Messrs. G. Cadbury and Co., Horlick's Malted Milk Co., Brin's Oxygen Co., Warner and Co., Clay, Paget and Co., Ltd., and the Charles H. Phillips Chemical Co., the Manhu Food Co., the Aylesbury Dairy Co., Messrs. Callard and Co. (a fine display of diabetic foods and jellies), Davidson and Co., Messrs. George Jennings, and the Plasmon Co., with their food specialities now so much in vogue with the profession.

PPROFESSOR BEHRING ON HIS DISCOVERY.

Paris, Saturday.—At the closing sitting this afternoon of the International Congress on Tuberculosis, under the presidency of Dr. Herard, supported by M. Casimir-Perier and M. Leon Bourgeois, Professor Behring made the following statement on the subject of his treatment of tuberculosis.

"In the course of the past two years I have come to recognise with certainty the existence of a curative principle completely different from the antiseptic principle described by me 15 years ago. This new curative principle plays the essential part in the immunising action of my bovo-vaccine, which for four years has been employed in agricultural practice in the battle against tuberculosis in cattle. This principle rests on the impregnation of the living cells of the organism by a substance coming from the virus of tuberculosis, which I call 'T C.' When the 'T C' becomes an integral part of the cells of the organism of animals treated by it, and it is metamorphosed by these cells, I describe it by the formula 'T X.'

"In the tuberculosis bacillus the 'T X,' or rather the 'T C,' persists as an agent endowed with a great number of extraordinary qualities. This agent fulfils the function in the tuberculosis bacillus of a formative substance. Besides this, it possesses fermentative and especially catalytic qualities. This agent is able to fix, in an electric manner by contact, other substances—a phenomenon which is called adsorption. Moreover, in certain conditions it possesses assimilative qualities. In a word, it represents the quasi-vital principles of the bacilli.

"In my view, in the process of the immunising of bovids against tuberculosis the 'T C' of the bacilli is freed from accidental substances, and it exercises a symbiotic action in the interior of the organic cells, and particularly in the cellular elements which derive from the germinative centres of the lymphatic tissue. The presence of the 'T C' is the cause, on the one hand, of the hypersensibility of Dr. Koch's tuberculine, and on the other hand of the protective reaction against tuberculosis. The road was long by which, after having overcome many obstacles, I arrived at the conception of the mode of anti-tuberculous immunisation. This conception of a cellular immunity is quite different from the antiseptic humoral immunity.

"I consider it a great honour to be able to make before the general meeting of the Paris Congress a short communication on the means of combating tuberculosis by a new remedy. I assume that my method of vaccination against tuberculosis in bovids is known. I have no need to insist on the point, but it will be readily admitted that I have taken into account all the possibilities of applying this process with a view to combating tuberculosis in man, but my experiments have made me firmly resolved to abandon definitely the idea of introducing living tuberculous bacilli into the human body with a therapeutic object.

"Condensing into a few words the results of my labours, I may say that to free the 'T C' from the substances preventing its therapeutic action, it is well to distinguish three groups of bacillary substances. 1. A substance only soluble in pure water, and possessing a fermentative and catalytic action. From this substance, soluble in water, are derived the toxic portions of Koch's tuberculine. This substance has all the chromophile-physical and chemical qualities of volutine described by the Marburg botanist Arthur Meyer. I call this substance 'T V.' To give an idea of the toxic powers of the 'T V' I may say that a gramme of this substance in a dry state is more powerful than a litre of Koch's tuberculine. 2. A globuline substance, soluble only in a neutral salt (for example, chlorite of sodium at 10 per cent.). This substance is called by me 'T G L.' It acts as a toxic in the manner of Koch's tuberculine. 3. Several non-toxic substances soluble only in alcohol, ether, chloroform, etc. A fundamental fact is that the 'T C,' a non-reproducible substance, nevertheless possesses the power of giving birth to tubercles. By experiments on different mammiferous animals I have been able to convince myself that the 'T C' can be elaborated *in vitro* in such a fashion as to make it a remedy which might also be applied, without danger, in human therapeutics."

Professor Behring made his communication in German, and Dr. Fuester then read the French translation, which was frequently applauded. Dr. Herard, the president, who was surrounded by all the foreign delegates, including Sir William Broadbent, announced that the next Congress would be held in the United

States in three years' time, and the Congress then broke up amid loud cheers.—*Reuter.*

Correspondence.

MONOTONY IN PRESCRIBING.

To the Editor of The Medical Press and Circular.

Sir,—The letter from Dr. Murrell, published in your last issue, raises points of the utmost practical interest. In medicine, as in most professions, men are apt to become the slaves of custom, and to confine their prescriptions to a few drugs. The medical practitioner who dispenses his own physic grows attached to his jug of quassia infusion, inasmuch as it is cheap, handy, and compatible with iron. Nothing could be simpler than the manufacture of that useful vehicle by casting a handful of quassia chips into an infusion pot. Why should the busy practitioner burden his brains with the particulars of a dozen other equivalent bitters, together with an endless top-hamper of more or less useless details of active principles, therapeutic actions, and compatibilities? If there are other bitters as cheap, convenient, and efficient, let the teachers of materia medica proclaim them from the housetops. Medical men want practical knowledge. Instead of that teachers and examiners go on adding incessantly to the already enormous mass of diffuse knowledge now taught under the heading of materia medica. From my point of view—as a modest worker buried in obscurity—it seems to me that the best thing for the future medical man would be to cut away three-fourths of a useless, or, at any rate, superfluous materia medica. It is no training of the student's mind to cram his brains with a voluminous pharmacopœia. Moreover, should he want training of that kind, Heaven knows it is exacted from him in a dozen other branches of study, such as anatomy and physiology.

Dr. Murrell has done well to call attention to the use a medical man makes in after-life of the vast cargo of materia medica lore he is forced to ballast himself with in order to reach the haven of qualification. May it set men's minds thinking of the real end and aim of medical education—namely, to turn out capable men with a sound knowledge of the principles of medicine and surgery and of its subordinate branches. Above all should I like to hear Dr. Murrell's candid views of what would be the best practical training for a student in materia medica. From a teacher and an authority of his experience, such an expression of opinion would be invaluable.

I am, sir, your faithfully,

One of the Old School.

Literary Notes and Gossip.

We understand that Sir Wm. Broadbent is engaged in collaboration with his son, Dr. John Broadbent, on a fourth edition of his well-known work on "Diseases of the Heart."

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The sudden death of Mr. W. B. Saunders, the well-known American medical publisher of Philadelphia, occurred last week.

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A movement is on foot to publish at an early date an "Encyclopædia of Urology," by various authors, in three languages—English, French, and German. Dr. Ernest Frank, of Berlin, will be Editor-in-chief, in collaboration in Germany with Drs. Israel, Trendelenberg, and Posner. Great Britain will be represented by Mr. Reginald Harrison, America by Dr. Young, and France by Drs. Guyon, Albarran, and Ponson.

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A work of considerable importance to the Army Medical Service has just been published through Messrs. Bailliere, Tindall, and Cox, by Lieut.-Colonel Robert Caldwell, F.R.C.S., on "Military Hygiene." A handy and practical manual on the subject was badly needed and as the author was a member of the recent Royal Commission on Field Sanitation, and has been in medical charge in India and elsewhere, his experience should prove valuable.

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Dr. Squire Sprigge has a work in the press, entitled "Medicine and the Public," which, we understand, will appeal to the public as well as to the medical profession, for everybody is concerned in the quality and efficiency of the medical service of this country, and in the legislative and social conditions under which that service is rendered. Mr. Heinemann will be the publisher.

Medical News.

Guy's Hospital Medical School.

The following entrance scholarships and certificates have been awarded:—Senior Science Scholarship for University Students—£50, Mr. C. G. Douglas, B.A., Magdalen College, Oxford; certificate, Mr. H. G. Chapple, B.A., St. John's College, Cambridge. Junior Science Scholarships—£150, Mr. M. A. E. Duvivier, Guy's Hospital Medical School; £60, Mr. T. D. M. Stout, Guy's Hospital Medical School, and Preliminary Scientific, M.B. class, Mr. A. Neville Cox, Derby School, equal, £30 each. Entrance Scholarships in Arts—£100, Mr. H. L. Hopkins, Owen's School, Islington; £50, Mr. A. H. Todd, Sherborne School. Guy's Hospital Dental School.—Entrance Scholarship in Dental Mechanics—£20, Mr. E. J. Archer and Mr. W. E. Guilding, equal £10 each. The following Entrance Scholarships have been awarded at the London Hospital Medical College (University of London) for the session 1905-6:—Price Science Scholarship, Mr. George Taylor; £60 Science Scholarship, Mr. E. C. Lindsay; £35 Science Scholarship, Mr. T. W. George; Price University Scholarship in Anatomy and Physiology, Mr. M. W. Flack (Oxford).

Royal Academy of Medicine in Ireland.

The 23rd annual meeting of the Royal Academy of Medicine in Ireland will be held in the Royal College of Surgeons on Friday next, October 13th, at 4.30 p.m., when reports from the General Council and the treasurer will be submitted, and the election of officers for the forthcoming session will take place.

Semi-Teetotal Pledge Association.

A meeting will be held on October 24th next, at 4 p.m., at the Mansion House, the Right Hon. the Lord Mayor, presiding, to further the aims and objects of the "Semi-Teetotal Pledge Association," which was established with a view to checking the pernicious habit of "drinking between meals." Tickets can be obtained of the secretary, S.T.P.A., 4, The Sanctuary, Westminster.

Charing-Cross Hospital Medical School.

The following Entrance Scholarships have been awarded:—The Epsom Scholarship (100 guineas), to Mr. E. G. H. Cowen; the Livingstone Scholarship (100 guineas), to Mr. N. H. Harrison; the Huxley Scholarship (55 guineas), to Mr. H. A. Farr; Universities Scholarships (each 72 guineas), to Mr. F. S. Poole and Mr. D. A. Powell. An Entrance Scholarship of 40 guineas has also been awarded to Mr. M. B. Bayley, and Universities Exhibitions of 36 guineas each to Mr. A. V. Poyser and Mr. J. F. Hornsey.

New Isolation Hospital for Mid-Cheshire.

The new joint isolation hospital for Mid-Cheshire, near Davenham, was opened last week by Mrs. Wilbraham, Delamere House, who was presented with a gold key. The hospital has cost £12,000, and contains 34 beds for scarlet fever and typhoid, to serve a population of 50,000, in the joint districts of Northwich rural, Northwich, Winsford, and Middlewich urban. It is the first joint hospital built under a compulsory order of the Local Government Board.

Parliamentary Association for Abolition of Vivisection.

The second annual report of the Parliamentary Association for Abolition of Vivisection has been issued. It contains a record of the work of the association during the past year and states that in December last the Parliamentary Association became an entirely independent body, retiring from the British Union for the Abolition of Vivisection in consequence of the unbusinesslike manner in which the managers of the union were conducting its affairs. A number of questions have been put in the House of Commons by the vice-presidents of the association during the Session. The committee have decided once more to approach all the members of both Houses of Parliament who have not already become vice-presidents of the Association and are not known to be pro-vivisectors. A letter drawn up by the committee is to be sent out during the recess in accordance with this decision.

Royal Veterinary College of Ireland.

The sixth session of this college was opened on Saturday last, when Professor G. H. Wooldridge delivered the opening address, and the medals and prizes won by the students during the year were distributed to them by His Excellency the Lord Lieutenant. Sir Christopher Nixon, President of the Board of Governors, presided, and the attendance was large.

Professor Mettam, Principal of the College, said that they could claim that the past session had been a successful one. They sent up for examination in the Royal College of Veterinary Surgeons during the past sessions 109 students. He found that the number of passes—67—was an admirable percentage. Of the 67 passes, 14 were with honours. Of these passes, seven had completed their curriculum for being licensed members of the Royal College of Veterinary Surgeons. The competitions had been unusually severe during the past session, and the students who had gained the medal, gained them on their merits in keen competition with their fellow students in the several classes.

His Excellency then distributed the prizes, after which Professor G. H. Wooldridge delivered an address on the subject of "Epizootic Lymphangitis." After the address Sir C. Nixon and Lord Dudley addressed the meeting.

North-East London Post-Graduate College.

The opening lecture of the Winter Session will be delivered at 4.30 p.m. on Friday, October 20, at the Tottenham Hospital, N., by Dr. Percy Kidd, Consulting Physician to the Hospital. The subject of the lecture, which is free to all qualified medical practitioners, will be "Pericarditis, and Its Effects."

Pass Lists.

University of Durham.

At the Convocation holden on Saturday, September 30th, 1905, the following degrees were conferred—viz.:

Doctor in Medicine.—Gerald Burton-Brown, M.B., B.S.Durh.; Joseph James French, M.B., B.S.Durh.; Allen Holmsted Hobbs, M.B., B.S.Durh.; John George Ogilby Hugh Lane, M.B., B.S.Durh.; Arthur Alan Miller, M.B., B.S.Durh.; George James Williams, M.B., B.S.Durh.

Doctor in Medicine for Practitioners of Fifteen Years' standing.—William Baron Cockill, M.R.C.S., L.R.C.P., L.S.A.; John Arthur Coleclough, M.R.C.S., L.S.A.; Frank Fowler, M.R.C.S., L.R.C.P., L.S.A.; George Martin Fox, M.R.C.S., L.R.C.P., L.S.A., D.P.H.; Charles Ronald Handfield-Jones, M.R.C.S., L.R.C.P., L.S.A.; Robert Thomas Herron, M.R.C.P., E. L.R.C.P., and S. I.; Thomas William Kelly, M.R.C.S., L.R.C.P.; John Paterson, L.R.C.P. and S. E.; Charles Edwin Solomon, L.R.C.P. and S., E.; Douglas Wilson Wright, L.R.C.P. and S. E., L.M.

Doctor in Hygiene. (*D.Hy.*).—Thomas Morrison Clayton, M.D., B.S., B.Hy., D.P.H.

Master in Surgery.—John George Ogilby Hugh Lane, M.B., B.S.Durh., F.R.C.S.; Joseph Collingwood Stewart, M.B., B.S.Durh.

Bachelor in Medicine. (*M.B.*).—Frederick Durnford Atkins, George Nixon Biggs, Hugh Boyd Cunningham, Saville James Fielding, James Glenny Gibb, M.R.C.S., L.R.C.P., Harshall Haver, Frederick Laverick, Cyril C. Lavington, William Ernest C. Lunn, Samuel L. McBean, John C. Norman, Robert Rutherford, Herbert J. Slade, M.R.C.S., L.R.C.P., Francis R. Snell, Tys Visser, James L. Wilson, M.A.

Bachelor in Surgery. (*B.S.*).—Frederick D. Atkins, George N. Biggs, Hugh B. Cunningham, Saville J. Fielding, James G. Gibb, M.R.C.S., L.R.C.P., Marshall Haver, Frederick R. H. Laverick, Cyril C. Lavington, William Ernest C. Lunn, Samuel L. McBean, John C. Norman, Robert Rutherford, Herbert J. Slade, Francis R. Snell, Tys Visser, James L. Wilson. M.A.

The following received the Diploma in Public Health (D.P.H.), viz.:—Thomas Henry Bishop, M.R.C.S., L.R.C.P., and Henry Curwen, M.B., Ch.B. Edin.

Society of Apothecaries of London.

The following candidates passed the Primary Examination (Part I), October 4th and 5th, 1905: *Biology*, G. F. Malden, J. B. Moore. *Chemistry*, J. B. Moore, S. W. Turtle. *Materia Medica and Pharmacy*, U. J. Bourke, A. C. J. Elwin, E. C. R. Fisher, J. B. Moore, E. A. Mordaunt, N. C. Wallis.

The following candidates passed the Primary Examination (Part II.) *Anatomy*, E. H. Crowley, M. Graves, J. G. Morgan, V. P. Norman, H. B. Waller. *Physiology*, W. J. Gibson, J. G. Morgan, G. Packham, H. B. Waller.

The Royal University of Ireland.

The Examiners have recommended that the following candidates be adjudged to have passed the Third Examination in Medicine:—

Upper Pass.—Raphael N. Berman, Joseph D. Cummins, Robert G. Kevin, James B. Lapsley, James F. Neary, John F. Neary, James A. Shorten. All these candidates may present themselves for the further examination for honours.

Pass.—Samuel Acheson, John W. Beirne, Joseph H. P. Boyd-Barrett, Edwin B. Brooke, Mary Cowhy, B.A., Robert Cox, B.A., James Dooley, Patrick Ferris, James J. Flood, Jane M. Fulton, Patrick J. Grogan, Charles E. L. Harding, James B. Horgan, Arthur H. Joy, Francis Keane, John J. Kearney, Richard R. Kirwan, Thomas P. Lineham, John S. McCombe, Augustine P. MacMahon, George H. Martin, Charles Murphy, Edward O'Reilly, Christopher J.X. O'Sullivan, John J. Sheil, Alexander L. Stevenson.

Royal Colleges of Physicians and Surgeons.

The following candidates have passed the preliminary examination as undernoted:—H. D. Gasteen (with honours), J. Boyce, H. E. Clarke, G. J. M. Fraser, J. J. Fitz-Henry, F. J. Graham, G. B. Haddon, B. H. Mellon, H. M. E. H. McAdoo, T. B. Newman, M. A. O'Callaghan, W. A. Swan, S. H. M. Stritch, H. R. Tighe, O. Trigge, F. Webster.

Under the will of the late Councillor G. Gillespy, the Gateshead Dispensary will receive £10,000.

It is announced that five of the members of the Commission on the Feeble-Minded have gone to America to study the arrangements for the care and control of the feeble-minded in that country.

We learn that the Odontological Society of Great Britain is prepared to receive applications for grants in aid of the furtherance of scientific research in connection with dentistry. Particulars will be supplied by the Scientific Research Committee, 20 Hanover Square.

Notices to Correspondents, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," 'Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

British Diplomas for Foreign Graduates.—Dr. N. A. A. Paris.—Most medical licensing bodies in this country will admit to their final qualifying examinations graduates of foreign institutions of recognised standing on proof being furnished that the course of study complies with the requirements of the General Medical Council. Applications should be made to the Dean, Registrar, or Secretary of the University or Licensing Body.

Erratum.—In the "Case of Hypermetropia, &c.," by Dr. Hubert Armstrong, reported in the Medical Press and Circular for October 4th, on p. 350, for "+6D" *read* "+3D."

Vegetarian (West Ham).—The man can hardly be called a vegetarian who takes milk, eggs, and meat soups. broths, and extracts in his daily food. It has recently been pointed out that various chemical poisons are contained in soup, as well as in such articles as tea, coffee and alcohol. It is not yet known what is the rôle played by food in the causation of cancer. Quite possibly it may be an infective process due partly or wholly to organisms introduced into the alimentary canal. In the present stage of science, however, it would be no less absurd to implicate food than to ascribe cancer to salt, or to say that it can be cured by a poultice of violet leaves. We can only wait for clearer knowledge and in the meantime shun the charlatan, qualified or unqualified.

QUACKERY *versus* GENERAL PRACTICE.

A "Society" journal informs us that the earnings of a successful West End beauty doctor so called, run easily into four figures. There is one lady who makes sufficient income out of the business to pay £1,200 a year rent for premises and keep a house in the vicinity of Hyde Park. She charges as much as ten guineas for operating on the face, and for merely manicuring the nails demands half a guinea. Five assistants are kept in addition to a book-keeper, a lady to receive patrons, and one young lady whose sole duty is to look after the advertising, while the struggling G. P. has to live frequently on next to nothing keep up the appearance of a gentleman and look on in depressing silence.

County Surgeon (Norfolk).—The operation for varicocele should not be undertaken indiscriminately. In the right place it is one of the most valuable of minor operations.

M. O. H. (Renfrews).—Surgeon-General Suruki, of the Japanese navy, has drawn attention the to excellent results obtainable by washing recent wounds with sterilised water and dressing them at once aseptically. The principle of this treatment is obviously sound and commonsense. The war surgery of the Russo-Japanese campaign is likely to have no little scientific value.

Strand.—We should advise you to have nothing to do with the firm in question. The fact of their advertisement to cure a dozen serious maladies by a single remedy, itself a secret, condemns the undertaking *ipso facto*.

T. A. S. (Leeds).—"Professor" Richard and his nefarious ways have long been disclosed to the public. Only a week ago *Truth* spoke of him as "that disreputable rascal," and pointed out how he had been in trouble with the police in America, Australia, South Africa and India. The fact that such a man is permitted to batten upon the public by means of his so-called "medical electricity" simply shows the inherent feebleness of our medical acts.

Buxton.—The individual has assumed various aliases, usually those of medical graduates, and on one occasion was fined for holding forth as a qualified practitioner, with a door plate, fortunately the profession will not be scandalised with his name for the next few years.

Meetings of the Societies, Lectures, &c.

Wednesday, October 11th.

Dermatological Society of London (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. Meeting.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. J. Berry: Clinique. (Surgical.) 5.15 p.m Dr. G. H. Savage: Senile Insanities.

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—5 p.m. Opening Address of Winter Session:—President of the Royal College of Surgeons.

Thursday, October 12th.

British Gynæcological Society (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. F. Edge. Papers:—Dr. B. Fenwick: (1) A Remarkable Case of Pulmonary Embolism; (2) Four Years' Hospital Abdominal Surgery.

Medical Graduates' College and Polyclinic, (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. L. Williams: The Therapeutics of some Common Ailments.

Post-Graduate College (London County Lunatic Asylum, Hanwell).—3 p.m. Dr. R. H. Cole: Classification of Insanity.

St. John's Hospital for Diseases of the Skin (Leicester Square W.C.).—Chesterfield Lectures —6 p.m. Dr. M. Dockrell: Eczema, its Varieties, Symptoms.

Mount Vernon Hospital for Consumption and Diseases of the Chest (7 Fitzroy Square, W.)—5 p.m. Introductory Lecture:—Dr. H. Campbell: The Enlargement of the Chest in Pulmonary Disease. (Post Graduate Course.)

Friday, October 13th.

Clinical Society of London (20 Hanover Square, W.).—8.30 p.m. Dr. D. Newman: Demonstration of the Cystoscopic Appearance in Renal Disease. Paper: Mr. E. M. Corner: A Case of Tuberculosis in a Diverticulum of the Bladder found in an Inguinal Hernia.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Dr. D. Grant: Clinique. (Ear.)

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. R. J. Reece: The Dwelling House and its Surroundings.

Vacancies.

Cornwall County Asylum, Bodmin.—Junior Assistant Medical Officer. Salary £135 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Kent County Asylum, Barming Heath, Maidstone.—Assistant Medical Officer. Salary £175 per annum, with lodging, attendance, coals, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

Westminster General Dispensary.—Resident Medical Officer. Salary at the rate of £120 per annum, with rooms, gas, coal, and attendance. Applications to the Secretary, 9 Gerrard Street, Soho, W.

Hull City and County Lunatic Asylum.—Second Assistant Medical Officer. Salary £150 per annum, with board, apartments, washing and attendance. Applications to the Chairman of the Asylum Committee, care of the Town Clerk, Town Hall, Hull.

Lunatic Hospital, The Lawn, Lincoln.—Assistant Medical Officer. Salary £100 per annum. Applications to the Medical Superintendent.

West Riding Asylum, Wadsley, Sheffield.—Fifth Assistant Medical Officer. Salary £140 per annum, with board, &c. Applications to the Medical Superintendent.

Incorporated Dental Hospital of Ireland.—Two Anæsthetists. Applications to W. A. Shea, Registrar. (See Advt.)

Appointments.

Brockbank, E. M., M.D., M.R.C.P.Lond., Honorary Assistant Physician to the Manchester Royal Infirmary.

Cornish, Charles Vivian, M.R.C.S., L.R.C.P.Lond., Resident Medical Officer to the Hampstead General Hospital, N.W.

Farmer, S. M.R.C.S.Eng., L.R.C.P.Edin., Certifying Surgeon under the Factory and Workshop Act for the Spennymoor District of the county of Durham.

Gallagher, J. O., M.D., C.M.Toronto., Clinical Assistant to the Chelsea Hospital for Women.

Kinnear, J. A. M.D., C.M. Toronto, Clinical Assistant to the Chelsea Hospital for Women.

Owen, A. D., M.R.C.S., L.R.C.P., Lond, Medical Officer to Post Office, Hampton and Hampton Hill.

Marriages.

Cooper—Cooper.—On Oct. 5th, at St. Peter's Church, Cranley Gardens, London, Harry Cooper, M.A., M.D., son of the late Henry Cooper, of Surbiton, to Elaina, fifth daughter of Edward Cooper, of 172, Cromwell Road, Kensington.

Dyer—Edwards.—On Oct. 5th, at St. Mary's, Sawston, Cambs, Arthur Reginald Dyer, A.M.I.C.E., son of John Herbert Dyer, of South Croydon to Dudley Beatrice, elder daughter of Frank Edwards L.R.C.P.Ed., of Tudor House, Sawston, Cambs.

King—Sharp.—On Oct. 3rd, at St. Andrew's Church, Derby, James W. King, M.B., B.S., of St. Leonard's House, Osmaston Road, Derby. eldest son of the Rev. James King, of Huddersfield, to Bertha, only daughter of Dr. J. A. Sharp, of Reading.

Taylor—Bowring.—On Oct. 5th, at Christ Church, Linnet Lane, Liverpool, William A. Taylor, M.B., Perth, son of the late Charles Selkrig Taylor, S.S.C., Edinburgh, to Mary Caroline, daughter of the late John Bowring, of Liverpool.

Deaths.

Bickle.—On Aug. 28th, at "Warra-Warra," North Terrace, Adelaide, Jennie, wife of Leonard W. Bickley, F.R.C.S., M.R.C.S., L.R.C.P.

Grant.—On October 5th, at 4 Sackville Gardens, Brighton, Surgeon-Major Alex Gibb Grant, Indian Medical Service (retired).

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, OCTOBER 18, 1905. No. 16.

Original Communications.

SCIENTIFIC RESEARCH IN MEDICINE.

INTRODUCTORY ADDRESS AT THE LONDON SCHOOL OF TROPICAL MEDICINE, DELIVERED OCT. 11TH, 1905,

By GEORGE H. T. NUTTALL, M.A., M.D., PH.D., F.R.S.,

Professor of Bacteriology and Preventive Medicine in Cambridge University.

IT is a pleasure and an honour for me to address you at the opening meeting of your nineteenth session, and I thank you for giving me the opportunity. Coming from Cambridge, where the importance of tropical medicine has been fully recognised by the institution of a University Diploma in Tropical Medicine and Hygiene, I feel that this is an occasion which can but strengthen the bonds that unite us in the desire to further our common object. I have chosen as a subject for to-day's address, "Scientific Research in Medicine," for my own work has been mainly connected with research.

That great benefits to mankind have followed the discoveries of recent years is obvious to all of us, especially with regard to the cause and prevention of yellow fever and malaria, and the results already obtained give abundant promise of the good that may result from like researches in the future. Research is a word we hear on all sides to-day. It is the enemy of mere *authority*, that tyrannous spirit which has hampered progress and retarded the advance of scientific medicine for centuries. The spirit of research is restless of restraint; it chafes at limits; it leads us ever onward to new questionings and new discoveries, and these in turn lead on to further inquiries. The spirit of research has come to stay with us as long as the hope and the desire of progress, in any domain of human knowledge, continue to stir the minds of men.

Experimental medicine is responsible for the greatest advances which have been made in our knowledge of the cause, prevention, and cure of disease. These advances have been based on the labours of many workers, exploring often along different lines. Most important discoveries have exerted but a slight direct effect at their inception; their full significance has remained hidden, except perhaps to the few and far-seeing. Of such discoveries the majority have been made by those engaged in research in the realms of pure science, and rarely by those guided by principles of direct and immediate utility. Pure science is in this respect unselfish; its aim is not profit, but truth; it makes for light, rather than for gain; yet it is the forerunner of that applied science which is more obtrusively the servant of man. Its guiding principle is that knowledge must be sought for its own sake, and not primarily for its possible or probable applications. And experience has shown that new and fruit-bearing knowledge is seldom revealed to those whose sole purpose is merely utilitarian.

Problems of the greatest importance to humanity are awaiting their solution at the hands of those who are willing to labour thus unselfishly, to devote themselves to science for the sake of science, and not for that of the material service which science can be made to yield. If we study disease, we must study disease for the sake of knowledge; the scientific spirit must enter into our work. Devotion to the study, actuated by such motives, is certain to bring its reward, although the reward may not be material. It seems scarcely necessary to dwell on this before an audience composed chiefly of men belonging to the medical profession, which of all the professions is the most unselfish. All that can be asked is that those who devote themselves to advancing the science of medicine shall bring to their work the same noble motives which guide the ideal physician in his efforts to alleviate the sufferings of his fellow-men. The spirit of commercialism should be as foreign to the man of science as it is to the physician, for both should be idealists in the best sense of the word. The fruits of their labours may be gathered by others, but none can rob them of the joy of having brought them forth. The "practical man" may not appreciate such ideals; he may deride those who cherish them; but he is ever ready to use the discoveries of science for his own ends. The reward of the true pioneer does not lie in what is said by "the fool multitude who choose by show"; he sees only "the wages of going on"; he finds his recompense in delving into the wonderland of Nature with all its hidden beauties, and thereby forgetting the smallness that enters into all men's lives. And there is no meanness in the exultation of the explorer when a new peak rises on his view, of the searcher of the skies "when a new planet swims into his ken." The joy of the hunter at the kill is felt by the scientific worker when a fact which has hitherto escaped observation rewards his patient search for truth.

Research has also its joys in the ever-changing picture that it brings before us; the phenomena we study fascinate through their very elusiveness. We must be prepared for many disappointments and much labour lost; we must be ready to give up much of the old, if we wish to grasp the new. We must grow with our growing knowledge *per ampliora ad altiora*. We must emulate the chambered Nautilus:—

> . . . Year after year
> Beheld the silent toil
> That spread his lustrous coil;
> Still, as the spiral grew,
> He left the past year's dwelling for the new,
> Stole with soft step its shining archway through,
> Built up its idle door,
> Stretched in his last-found home, and knew the old no more.
> —*O. W. Holmes.*

We are not all born with instincts fitted for research, but there are many in whom the talent for investigation lies dormant and unused. It should be one of the functions of educational institutions to detect such men, and to lead them on to do the work for which they are adapted, to place the torch within the grasp of hands that are fit to bear it onwards.

Endowment of Research Needed.

All who are engaged in teaching and research have met with such men, and often with regret have been forced to see them drift away into other fields of activity, too often from mere lack of means to offer them encouragement. In this country we constantly see men abandon research for practice, though it is all too obvious that, in the interest of science, we cannot afford to lose them. In such cases the distinction attained by research is used but as a stepping-stone to positions which shall secure a means of livelihood. To carry on research successfully a man needs an assured income so that his mind may be at peace with regard to his material wants. How little encouragement is needed to bring forth such men is seen to-day in many parts of the world. I need scarcely remind you of the devotion to work for its own sake exhibited by such men as Lazear, Myers, Dutton, Plehn, and others, who have sacrificed their lives in the study of tropical medicine. These men consciously risked their lives in their devotion to science, they sacrificed themselves for humanity, and there are many who are prepared to follow in their footsteps.

Is it possible that those who are able and willing to help on human progress can continue to ignore the devotion and self-sacrifice which such men are all too ready to render to their fellow-men? We should do all in our power to bring the need in this respect before the educated public, in whose mind there still exists no proper understanding of the material conditions that render scientific research and discovery possible. The average man is scarcely interested in *how* discoveries are made, provided that they *are* made; but an appeal to him based on grounds of public benefit may meet with success; and such an appeal is justified by what has been accomplished.

The needs of experimental medicine are so great and urgent that every means short of the undignified should be taken to bring the matter forcibly before the public, which in this country does so much for charity, so pitiably little for the advancement of learning. Medical research needs endowment. For those who are willing to devote their lives to research, means of subsistence should be found in the interest of the public good. In the regrettable absence of State aid we are forced to appeal to the intelligent public, proving again and again that we need help and still more help, and that we are worthy to receive it at their hands. In this appeal all medical men should join.

The wealthy classes of this country would do well to imitate their brethren in America, where, though the State does much more for learning, private beneficence has nevertheless come to the fore in splendid fashion, endowing universities, institutes, and laboratories in a truly regal manner. It is high time that medical science should become a more favoured object of benevolence in this country.

Our Laboratories and Teachers.

In an address delivered by my friend, Professor W. W. Welch, of Johns Hopkins University, some nine years ago, he said:—"At the present day no country, no university, no medical school, can hold even a respectable place in the march of education and progress unless it is provided with suitable laboratories for scientific work." Laboratories are the workshops of those who engage in research, although there are some in which much routine work is done and original research neglected. Laboratory work alone does not constitute research. Laboratories should be thoroughly equipped and guided by men of capacity, by well-trained teachers and investigators who can give their whole time to the work, not by men "deep versed in books and shallow in themselves." The teachers should be men capable of fostering the scientific spirit in medicine and of training the students under them in objective methods. For this purpose the best teachers are unquestionably those who are also investigators, but to fulfil both the functions of teacher and investigator requires so much time that it is almost impossible to perform any other duties. A non-investigator may cram his students excellently for such purposes as examinations, but he will not stimulate his men to progress in independent thought and work. To teach science as it should be taught in properly equipped and organised institutions is far more expensive in the case of medicine than in that of any other professional school; and this is the reason why support is so much required—pure science does not pay for the material needs of those who cultivate it.

In former times our needs were fewer, but it no longer holds true that "what was good enough of old is good enough yet." The result of clinging to the old traditions has brought about an untenable position among science teachers in this country. In many of our institutions, one man is often expected to perform duties which in more enlightened Germany are allotted in two, three, or even more teachers, each provided with a living wage apart from the necessary support given for their laboratories. Most teachers of science in this country receive pittances of which few are sufficient, many totally inadequate. The same holds for many of our laboratories, which remain ill-provided with the means of making use of the costly bricks and mortar, of which, in some cases, they are constructed. I know of cases where even university teachers have to sacrifice a large share of their insufficient salary in carrying on the work of research in their laboratories. It does not suffice to *build* laboratories; they must also be provided with sufficient funds and equipment to enable them to become working entities. In brief, we need living laboratories; we must see that the teacher is supported in a manner commensurate with his functions, and that aid, however modest, is found for such students as show a marked talent for research.

I have cited conditions in Germany as an instance of what is done in a neighbouring country by a "paternal Government." A closer study of these conditions should certainly tend to ruffle the national pride of an Englishman. Take a single instance with which I am especially familiar—the hygienic laboratories. In May of this year the new Hygienic Institute of the University of Berlin was opened. The building, which contains all modern appliances, was constructed at a cost of £35,000. Ten years ago the Institute received £925 per annum for current expenses; this year the "Etat" has been brought up to £1,750 per annum, this apart from the salaries to the teaching body, and from grants for special investigations. Every German university and most towns of importance are provided with hygienic institutes, all, as far as practicable, supplied with means adequate to enable them to perform their useful functions. Even in poverty-stricken Italy practically every university is provided with a hygienic institute, which serves, as in Germany, as an active centre for research and teaching. Compare this with what is found in this country. There are hygienic laboratories in Edinburgh and Manchester, which may modestly compare with some of the institutions abroad. Take Oxford and Cambridge, our oldest universities, and we see that no provision exists for research or even proper teaching in hygiene. It seems inconceivable to outsiders that these universities are poor, and cannot found new institutions, and that there are other and perhaps more pressing needs. All I can say, in the words of a talkative Irish patient, I know "Poverty is no disgrace, but it is mighty unhandy"—and we must continue to hope for better days. We in Cambridge are earnestly hoping that a helping hand may soon be extended to the relief of a condition which cannot persist.

The London School of Tropical Medicine and its Students.

Those of us who have watched the progress of this school from its inception, have witnessed a struggle upward which is worthy of all praise and felicitation. This and the sister institution in Liverpool are known throughout the world, for the excellent work accomplished by the members of the teaching staffs, and some of the students they have sent forth. Your school has a great mission to fulfil. It has to train men in the methods they will be called upon to employ in many parts of the world, and to give them the latest and the best to take with them on their distant journeys. The amount crowded into your courses already shows the rapidly increasing importance of the subjects treated and the need, some day in the future, of making certain modifications in the plan of study so as to relieve the increasing burden on the teacher and student.

It is to be hoped that the public will second the noble efforts you have made to establish a centre for the study of the diseases which affect the inhabitants of the tropical countries of this vast Empire. You have already made your influence felt throughout the world, for the men trained within these walls are constantly being distributed over the Empire, and occupy places where they will continue to transmit the stimulus which radiates from this institution. We are at length beginning to see the dawn of better days, when we ourselves can supplement or solve the great problems which it is our duty to investigate without calling in, as heretofore, the men whom Germany and France have trained and lent us in our helplessness.

> " All things by season season'd are
> To their right praise and true perfection ! "
> —*Merchant of Venice*, Act v., sc. 1.

There is much for us to do before we reach " perfection," and we must continue to stride onward and upward. I should like to see some means devised, for instance, in this school, to maintain a form of union between those who have enjoyed the opportunity of studying in its laboratories, to see arise a feeling of corporate attachment between the institution and those who have passed through its portals. This might be accomplished by the publication of a " Bulletin " or the like, which would serve to keep the men in touch with each other and with their teachers after they have left the school. This school, for its part, would surely benefit by fostering the ties which unite it with its former students. The grown-up sons who are out in the world would be encouraged to remember, and on occasion to support and assist their *alma mater*.

The examination which we have instituted at Cambridge cannot fail to react upon the schools where tropical medicine is taught in the direction of broadening and deepening the knowledge imparted to those destined to present themselves as candidates. For instance, it has already become obvious to us that the subjects of tropical hygiene and bacteriology require more attention than they have received at the hands of those desiring to attain our diploma. It is fully recognised that there are difficulties in the way of lengthening the curriculum or of increasing the amount of study in the period which is at present allowed for the courses in tropical medicine. But it is obvious that some gain might result from a stricter choice of subject-matter. The study of tropical medicine has often been referred to as a special study, but it embraces a very wide range of knowledge and in practice is constantly spreading into the realm of general medicine. To have a sound knowledge of tropical medicine presupposes as sound a knowledge of general medicine. It follows that those who turn to the study of tropical medicine should do so on a basis of sound general knowledge.

The necessity of giving as much *practical* instruction as possible is obvious to us all in an institution such as this. Men can take books with them to the tropics, but they rely on their practical training for methods. To put a cookery-book in the hands of a woman who cannot distinguish between pepper and salt would be to court disaster. Instruction in general principles will make it clear that methods are not stereotyped ; they are but aids to obtaining a result ; they must be varied according to conditions ; and new methods must be evolved to meet unexpected difficulties. That is where the untrained man breaks down ; in face of a new situation, he cannot go beyond his book. If he has not learned in the laboratory how methods are evolved and adapted to particular problems as they arise, he is helpless and barren. He has " no root in himself."

It would be well to sound a warning to young workers as to the value of good methods and thoroughness in work ; to counsel patience in research ; to emphasise the wisdom of avoiding the tendency to undue haste in publication, and to ridicule the love of publicity and advertisement that has seized upon some of our brethren at home and abroad. These failings discredit not only scientific men, but science itself, for they lead to over-hasty and unwarranted generalisations, and to the premature application of discoveries that are not half-born. A carelessly worked-out contribution to science, even though it be but a maiden effort, often throws discredit on the good work which a man may do in after years. This damaging result is often risked in the struggle for recognition ; but the penalty is sure, for it is at least as difficult to recover a reputation in science as it is in morals. If some seem inclined to deprive others of their due by loud trumpeting and " pushfulness," let us not be of them ; reputations so achieved have no enduring quality. At the same time it would be well if those holding established positions did all in their power to assure just recognition of the work done by younger men. To win the praise of the masters should be the ambition, and the attainable reward, of the aspirant. Finally, well-trained men, when entrusted with investigations, or sent out on expeditions, should not be burdened with too many instructions from committees and the like, composed frequently of well-intentioned gentlemen at home, who scarcely understand the conditions at the front. We speak of fair-play in sport ; let us see that there is more fairplay in science.

The Trend of Recent Investigation.

A survey of recent work is tropical medicine shows us that investigation is chiefly being directed to the study of protozoal diseases. No advances of fundamental importance have been made with regard to malaria since the classical investigations were published with which the names of Ross and Manson, Grassi, Bignami, and Bastianelli, will ever remain associated. The earlier work has been confirmed and extended by many investigators. The prevention of malaria by means of mosquito destruction, and other measures directed against mosquitoes, has been tried in various localities, in some instances with success, in others with doubtful results. This is, however, only what might be expected in view of the diversified difficulties which must necessarily arise. Such difficulties must be met and overcome by ripening experience. There has been a veritable flood of malaria literature of recent years, including an annual volume of " Atti della Societa per gli Studi della Malaria," the series commencing in 1900, which has come to us from Italy. Mosquitoes have received an immense amount of attention, after being much neglected in the past. The number of genera and species and their classification have become subjects to bewilder all but specialists.

The important discoveries on sleeping-sickness ushered in by the researches of Castellani, a pupil of this school, have been confirmed and extended by Bruce and his collaborators of the Sleeping-Sickness Commission. The relation of the flies belonging to the genus glossina to the transmission of the trypanosomes is being actively studied, and many important questions we must hope are nearing their solution in connection with this most fatal malady. A contribution has just come to hand from Gray and Tulloch with regard to the multiplication of the parasites in glossina, indicating that the belief recently expressed is warranted, namely, that the parasites undergo a cycle of development within the insects. Of importance in their bearing on the question of the development of trypanosomes in other than their vertebrate hosts are the investigations of Schaudinn on trypanosoma noctuæ in culex, those of Brumpt on certain trypanosomes of fishes, which undergo their cycle of development in leeches, and those of Prowazeck on the rat trypanosome, which he has demonstrated undergoes development in the rat louse (Hæmatopinus spinulosus).

Of recent discoveries, the one which to me appears to carry the greatest weight, is that of Novy and McNeal. They have been the first to obtain pure cultures of protozoa, maintaining trypanosomes of different species alive *in vitro* for many generations. There is no telling whither the methods they have given us may lead; they directly stimulated Leonard Rogers to experiments wherein he succeeded, by an ingenious method of his own, in cultivating another protozoon, the Leishmania, obtained from cases of kala-azar.

The work on the tick-transmitted diseases known as the piroplasmoses (redwater, &c.), occurring in cattle, sheep, horses, and dogs, has been pursued in various parts of the world with great activity. The results appear to me to indicate what I believe also holds for human malaria parasites, that we shall in time learn to distinguish different parasites which we at present consider to represent single species.

The investigations of Dutton and Todd on tick fever in the Congo Free State, announced in February, have gone to prove that this disease is transmitted by a tick (ornithodoros Savignyi) after it has infected itself with blood containing the spirochætæ. This has been confirmed by Koch, if we may rely on what has appeared recently in German newspapers. It is, however, quite premature to assume that African tick fever and European relapsing fever are due to one and the same species of spirochætæ; in fact, it is highly probable that this is not the case, although the report in question refers to the spirochætæ as one species. In relapsing fever in Europe the bed-bug (cimex) has long been suspected to be a carrier of the infective agent, a probability which was considerably heightened by Karlinski's observation of motile spirochætæ in the bodies of the insects up to thirty days after they had fed on relapsing fever blood. Schaudinn, moreover, informs me that he has observed the multiplication of the spirochætæ obermeieri in cimex. These observations, following closely upon those published by Marchoux and Salimbeni, are of greatest interest and practical import. The last-named authors demonstrated that a fatal disease of the fowl in Brazil is due to spirochætæ transmitted through the agency of a tick (argas miniatus), and capable of conveying the disease even six months after feeding on infected blood. These spirochætæ multiply in the tick and are present in large quantities in its body cavity throughout this period. These observations are very suggestive, since they demonstrate the long persistence of the parasites in their carriers, and render it probable that they will be found to be harboured much longer. Finally, the finding this year of spirochætæ pallida in syphilis by Schaudinn and others in man, and by Metchnikoff and Roux in experimentally infected apes, cannot escape a passing notice even though the disease is unfortunately not confined to the tropics. It is of some interest to note that the close blood-relationship existing between the apes and man, demonstrated independently by means of the precipitins by Grünbaum and myself, served as a direct incentive for the experiments of Metchnikoff and Roux, Lassar, and Neisser, which proved that human syphilis is communicable to the chimpanzee and orang outang.

Of interest has also been the discovery this year of a number of new protozoal parasites in the blood of different animals, in addition to numerous new species of trypanosoma. I refer to new forms called "leucocytozoa," because they inhabit the white blood corpuscles of their vertebrate hosts. Leucocytozoa were first discovered by Bentley in dogs in India, and were described, without sufficient mention of this fact, by James. Another species has been found by A. Balfour in the rat (M. decumanus) in Khartoum; and, lastly, W. S. Patton informs me that he has found a species in the squirrel (sciurus palmarum) in India, and apparently observed developmental forms thereof in a louse. Balfour has, moreover, described a new hæmogregarine occurring in the Jerboa (jaculus jaculus), and Graham-Smith, in our laboratory, has found another new endoglobular parasite in the mole. This by no means exhausts the "finds" of this year, but it will suffice to show that British workers are doing their share in furthering our knowledge in this regard.

Of the diseases due to vermes I can say but little. The discovery of Catto's schistoma in this laboratory is familiar to you all. It is interesting to note, following on the experiments with ankylostoma duodenale by Loos, proving that the embryo worm can infect by penetrating through the skin, that Boycott in London, and Tenholt in Germany, have confirmed the fact this year in two experiments conducted on medical men who volunteered for the puropse.

Again, it is apparent that the subject of immunity in relation to protozoal diseases is proving to be one of great difficulty, and the results hitherto obtained indicate that new methods will have to be devised if the problem is to be solved from a practical, and still more from a scientific, standpoint. It is also obvious in this connection that the problems before us can only be solved by animal experiment, and this accentuates the need of our giving an increasing amount of attention to comparative pathology as we push on toward the alleviation of the ills to which our own flesh is heir.

Gentlemen, I must apologise for the very sketchy nature of the *résumé* which I have just given you. There are many matters left untouched, including even such important diseases as yellow fever and Malta fever, on which active work has been done. My object has been to seize upon a few salient facts, with a view to showing how mnch has been accomplished within a short period, and how great are the opportunities of the workers in this school who are destined to labour in new fields in different parts of the world. Perhaps what I have said—in no spirit of presumption—will serve as an incentive to some of my hearers. Let me conclude with some wise words from the Talmudi: "The day is short, and the work is great. It is not incumbent upon thee to complete the work, but thou must not therefore cease from it."

CLINICAL CASE-TAKING. (*a*)

By SIR JOHN W. MOORE, M.D.DUB.; D.Sc. OXON.; F.R.C.P.I.;

Physician to the Meath Hospital.

To write an Inaugural Address in this busy Twentieth Century is no easy task. There is so much to be done, so much land to be traversed in the quest for knowledge, that neither lecturer nor audience can spare the needful time for an old-fashioned ceremonial, which is now more honoured in the breach than in the observance. But in the Meath Hospital, with its traditions of more than a century and a half (*b*), the custom of beginning the session with an address survives. Therefore it is that I stand here to-day and crave your attention for a few moments to bring home to your minds and consciences the solemnity of the calling which you have adopted as your life-work—the innate nobleness of the Profession of Medicine. Yes, the profession of medicine is a solemn calling, look at it how we may. It has a threefold aim: to preserve man's health, to restore man's health, or—where that is impossible—to assuage human suffering and to mitigate the pains of death. The preservation of health is the province of preventive medicine; the restoration of health is the object of curative medicine. Surely the ministers of such a high calling should approach their godlike work with reverence and awe, yet also "in stille Demut und Hoffnung"—in calm humility and hope.

It would be indeed unkind—yes, even ungenerous, on my part—if I said anything in this address with the intent to damp your ardour in the study of the profession of your choice. Yet, in all sincerity I am bound to tell you that you have started on a journey which lies along no "primrose path" but one beset by thorns.

(*a*) An Address introductory to the Session of 1905-6, delivered in the Meath Hospital and County Dublin Infirmary on Monday, October 9th, 1905.

(*b*) The Meath Hospital on the Coombe was opened March 2nd, 1753.

Hard work, self-denial, and perchance disappointment in the end await you. A story is told of John Abernethy, that at an introductory lecture at St. Bartholomew's Hospital, when he had been received, as usual, with great applause, he appeared utterly indifferent to the plaudits which greeted him, but quietly casting his eyes over the assemblage, burst forth in a tone of deep feeling, "God help you all! what is to become of you?" In *The Practitioner* for August of the present year, an anonymous writer, discussing the question of "Medicine as a Means of Livelihood," as it were paraphrases Abernethy's exclamation in the following words:—"It has often been remarked that the medical profession is the only one that works for its own undoing. To it mankind owes hygiene, which has already rid the world of not a few scourges, and which may in time stamp out disease. The triumph of hygiene means the passing away of medicine. The art of healing must necessarily become superfluous when there is nothing to heal. Already there are signs which seem to indicate that at least in certain directions the doctor's occupation will, at no very distant day, be gone. It is becoming increasingly difficult for the medical practitioner to make a living. As a friend of ours tersely put it, 'There's not enough acute disease to go round.' Other causes contribute to the same end. We have taught the public how to prevent disease, and the manufacturing chemist has taught them how to treat themselves. Hospitals send the rain of their free advice and physic alike on the poor and on those who can well afford to pay. Massage, electricity, and special forms of treatment are largely in the hands of men who are not of the household of medicine. Quacks of all kinds compete with the lawful practitioner. Should the doctor plead *Il faut vivre*, the public will soon be in a position to reply, *Je n'en vois pas la nécessité*. It is difficult to indicate a remedy for a state of things that is largely a consequence of the operation of inexorable economic laws."

And yet I cannot despair of the future which lies before you when I recall to mind the truthful, if somwhat vauntful, motto of this Institution—

"Quæ regio in terris nostri non plena laboris!"

Medicine has been classed with the "Learned Professions," but in these latter days its reputation as a learned profession is at stake. Even in the ancient universities of Oxford, Cambridge, and Dublin, the "old order changeth, giving place to new." Cambridge long since surrendered the requirement of an Arts Degree for graduation in medicine. Oxford, and more recently Dublin—the latter the youngest of the three academic sisters—while still requiring an Arts degree, have so whittled down the Arts course for medical students that it is scarcely recognisable as such. And yet a liberal education in Arts is indispensable if our object is to turn out the best brand of a physician or a surgeon. The intellectual powers must be carefully drawn out—this is what the word "education" means—the mind can be developed only by constant practice. The student's powers of observation must be trained day by day till they become part of his being—even his second nature. He should learn to reason about observed facts, to arrive at a diagnosis from symptoms and physical signs, and to form an opinion as to the proper treatment of his patients, as to the prospect of recovery (prognosis) and as to the future management of the case.

The idea is perhaps Utopian, but in my judgment it would be well for the medical profession and for the public alike if a university training and a degree in Arts formed part of the "making" of every physician and surgeon. There are, I admit, immense difficulties in the way. Time and means are wanting, in many instances, and the weighty medical curriculum itself forbids the student to linger in the groves of the Academy or to ponder the lessons of the *Stoa he poikile*.

Nevertheless, to one and all I say strive to secure, even at the cost of personal ease, the lasting and far-reaching benefits of a liberal, and, if possible, a university, education. Then, indeed, will you approach the study of medicine with a receptive and well-trained mind, but above all with a lively sense of the grave responsibilities you are about to undertake and the full significance of the healing art.

My special object on this occasion is to impress upon you the paramount importance of a regular daily attendance at the hospital, or rather I should say at the bedside of the sick. Far be it from me to decry the work you are called upon to do in the dissecting rooms, the laboratories, and the lecture theatres of the medical schools. A ripe and practical knowledge of anatomy, and a sound acquaintance with physiology and histology, chemistry and physics, are essential, and medical authorities do well to insist upon a curriculum which will teach, and examinations which will ensure, a knowledge of these all-important ancillary subjects. But, when all is said and done, the preparation for your life-work will have to be carried on in the out-patient department, the clinical wards, the operating-theatre, and the *post-mortem* room of a well-equipped general medico-chirurgical hospital, such as that within the walls of which we are assembled.

Let us hear a most competent authority on this subject. "How can we make," he writes, "the work of the student in the third and fourth years as practical as it is in his first and second? I take it for granted we all feel that it should be. The answer is, take him from the lecture-room, take him from the amphitheatre—put him in the out-patient department, put him in the wards. It is not the systematic lecture, not the amphitheatre clinic, not even the ward class—all of which have their value—in which the reformation is needed, but in the whole relationship of the senior student to the hospital. During the first two years he is thoroughly at home in the laboratories, domiciled, we may say, with his place in each one, to which he can go and work quietly under a tutor's direction and guidance. . . . My firm conviction is that we should start the third-year student at once on his road of life. Ask any physician of twenty years' standing how he has become proficient in his art, and he will reply, by constant contact with disease; and he will add that the medicine he learned in the schools was totally different from the medicine he learned at the bedside. The graduate of a quarter of a century ago went out with little practical knowledge, which increased only as his practice increased. In what may be called the natural method of teaching, the student begins with the patient, continues with the patient, and ends his studies with the patient, using books and lectures as tools, as means to an end. The student starts, in fact, as a *practitioner*, as an observer of disordered machines, with the structure and orderly functions of which he is perfectly familiar. Teach him how to observe, give him plenty of facts to observe, and the lessons will come out of the facts themselves. For the junior student in medicine and surgery it is a safe rule to have no teaching without a patient for a text, and the best teaching is that taught by the patient himself. The whole art of medicine is in observation, as the old motto goes, but to educate the eye to see, the ear to hear, and the finger to feel takes time, and to make a beginning, to start a man on the right path, is all that we can do." (*a*)

These weighty words were written by the pen, and fell from the lips, of William Osler, that famous and erudite physician, whose birthplace was Canada, who spent many of the best years of his life in the Johns Hopkins University and Hospital, Baltimore, U.S.A., and whom His Majesty the King recently called to Oxford as Regius Professor of Medicine in that ancient and storied seat of learning. You will no doubt endorse Dr. Osler's next words—"We expect too much of the student and we try to teach him too much. Give him good methods and a proper point of view, and all other things will be added as his experience grows."

I cannot forbear quoting two other paragraphs from

(*a*) "The Hospital as a College." An Address to the Academy of Medicine, New York, 1903.

the same address: "I envy," says Professor Osler, "for our medical students the advantages enjoyed by the nurses, who live in daily contact with the sick." And again: "The objection often raised that patients do not like to have students in the wards is entirely fanciful. In my experience it is just the reverse. On this point I can claim to speak with some authority, having served as an hospital physician for more than twenty-five years, and having taught chiefly in the wards. With the exercise of ordinary discretion, and if one is actuated by kindly feelings towards the patients, there is rarely any difficulty. In the present state of medicine it is very difficult to carry on the work of a first-class hospital without the help of students. We ask far too much of the resident physicians, whose number has not increased in proportion to the enormous increase in the amount of work thrust upon them, and much of the routine work can be perfectly well done by senior students."

The views just enunciated were also held by Graves and Stokes, those illustrious men whose names are on the beadroll of the physicians of this hospital, and of whom we are so justly proud. The foremost clinical teachers not only of the present, but of the past have over and over again insisted on the supreme value of hospital practice to the student of medicine. Long years ago the great surgeon, Abernethy, said: "The hospital is the only proper College in which to rear a true disciple of Æsculapius." In an introductory lecture delivered in 1867, Oliver Wendell Holmes expressed the opinion that 'the most essential part of a student's instruction is obtained, not in the lecture room, but at the bedside. Nothing seen there is lost; the rhythms of disease are learned by frequent repetition; its unforeseen occurrences stamp themselves indelibly on the memory. Before the student is aware of what he has acquired he has learned the aspects and causes and probable issue of the diseases he has seen with his teacher and the proper mode of dealing with them, so far as his master knows."

I have thus insisted on the value of hospital practice to the student of medicine because of late years I have observed a growing tendency to neglect the golden opportunities of acquiring professional knowledge and experience which the clinical wards afford. Case-taking, in particular, has not kept pace with other departments of medical study. The attendance at hospital has become spasmodic and intermittent. Over and over again I have missed familiar faces from the clinical class, and asking for an explanation I get the unvarying reply, "Oh, they are reading for such and such an examination." This is, I conceive, the deadly peril of sessional examinations under the modern five years Scheme of Medical Education. The danger has already attracted attention, and the University of Dublin in the new Regulations of the School of Physic in Ireland has adopted a remedy. Sessional examinations at the end of each *Annus Medicus* are given up, and in future medical students of the School of Physic will have to pass a Preliminary Scientific and only two professional examinations—the Intermediate Medical and the Final. It will be objected that the student will become careless in his attendance on the courses of lectures in each session if he has not before him the threatening nightmare of a fast approaching examination. This is guarded against by requiring the student to pass a class examination at the close of every course of lectures before he obtains credit for that attendance. Furthermore, the Preliminary Scientific examination in (*a*) chemistry and physics, and in (*b*) zoology and botany, may be passed in two groups, while the Intermediate Medical is also divisible into two parts, which may be taken in successive years, if so desired. This reform might well engage the serious consideration of the other Licensing Bodies,—particularly the Royal Colleges of Physicians and Surgeons, Ireland, which are at the present moment revising the regulations for candidates under the Conjoint Scheme. Meanwhile, I cannot too strongly express my conviction, based on personal experience, that the modern curriculum and its sessional examinations too far engross the student's attention to the prejudice of his hospital attendance.

And now a word of advice as to the best method of utilising the opportunities which present themselves to you within the sacred precincts of the hospital.

Too many members of the class are content with a perfunctory attendance. They arrive punctually perhaps at nine o'clock in the morning, mechanically follow the physician or surgeon as he passes through the wards, but are all attention when a rare or "interesting" case is reached. They may even come armed with a note-book, in which "tips" of all kinds are duly entered. Or they may appear half an hour late, and spend some precious moments in seeking the whereabouts of their clinical teacher. Or they may come one day and stay away the next, thereby losing all continuity of work in the wards. Those who thus attend hospital will never gain Experience—that priceless possession which at one time was within their reach, had they but realised the fact, but which perhaps they have for ever lost. The point I desire to emphasise with all my power is the absolute necessity of case-taking if a student really wishes to turn his hospital attendance to the best account. He has no excuse for not being a case-taker. On the first clinical morning of every winter session he receives a copy of a Synopsis of Clinical Instruction, which my colleagues and I prepared with great care a few years ago. It includes, in addition to a full description of the methods of physical examination adopted in our medical wards, valuable suggestions for taking cases. These were originally drawn up by our late distinguished and much lamented colleague, Dr. Arthur Wynne Foot, one of the ablest and most successful clinical teachers whom Dublin has ever produced. In the forefront of this booklet the following paragraph occurs:—"The physicians will facilitate in every way clinical case-taking by members of the class. At the close of the summer session a special prize of three guineas will be awarded for the best series of clinical reports of six cases taken during the preceding hospital year."

Let me in this connection clear up a possible misapprehension as to the meaning of the term "Clinical Clerk" in the Regulations of the various licensing bodies. It means simply a case-taker—but the cases should be taken fully, one daily visit at least being paid to the patient who at the time being is the "case." On my colleagues' behalf and my own, I may answer for it that we shall not be wanting in readiness to fulfil our part. We will at all times be ready to entrust one or more of our patients to members of the class who express their desire to become "Case-takers" or "Clinical Clerks"—using the latter term in its fullest sense. Do you, the students, see that you are equally ready and willing to fulfil your part, and, although it is true that "they which run in a race run all, but one receiveth the prize, yet so run that ye may obtain." If you do, you will never regret the effort, for even should you fail to win the prize for clinical case-taking the insight into disease which you will have obtained, the practice of expressing yourself clearly which you will have acquired, will in themselves be a prize worth far more than "gold that perisheth."

The fact is that literary composition requires constant practice. May I commend to your notice a small work recently published, which will put you on your guard against faults in writing? It is entitled "Notes on the Composition of Scientific Papers" (*a*), and was written about a year ago by Dr. Clifford Allbutt, F.R.S., Regius Professor of Physic in the University of Cambridge.

The author gives some amusing examples of literary errors and inelegancies. "Not long ago," he tells us, "a well-known physician wrote of 'vocal fremiti'! In editorial paragraphs of smart newspapers I have lately read of 'omnibi,' and even of 'non possumi'; in a well-known book by a celebrated author we are told that 'the hands of the Scipii were nailed to the rostræ"—blunders which remind us of Frank Lock-

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(*a*) London: Macmillan and Co. 1904. Crown 8vo.

wood's jest, 'They will apply for a mandamus! Then we will apply for a brace of mandami.'" Here is what Dr. Allbutt calls a "loose sentence": "He was struck down by an attack of brain fever, producing acute delirium, which lasted two months, but from which he completely recovered before the autumn." One laments bitterly the sad fate of the poor hypodermic injections in this sentence: "Twenty-eight patients were treated with hypodermic injections, of which eight died." Talking of deaths, here is a grim blunder in composition culled from a statistical paper: "Of the 276 deaths, 16 had gall-stones." Take care that you arrange your words in the right order, or you may make mistakes like the following: "His memory ought to be honoured by interment in Westminster Abbey." "Erected to the memory of John Phillips, accidentally shot as a mark of affection by his brother." "I understand that when he died Cardinal Mezzofanti spoke at least fifty languages." Dr. Allbutt tells us that a candidate read to him from a thesis for the Degree of Medicine at Cambridge, the sentence: "I could, when killed, discovered nothing abnormal."

In concluding this interesting book, Dr. Allbutt says: "Let the student read by all means, and read widely, not to imitate individual form, but to store his mind with ideas of thought and imagination, and with words in all their variety and significance. Let him converse with great authors, in poetry as well as in prose; for poetry is literature at its highest and strongest; and almost all poets—I say 'almost' to avoid contention—have written fine prose. Let him train his mind also to think and imagine continuously without fatigue, as he trains his body to endurance."

May I ask you, finally, in writing to avoid manufacturing Latin plurals of words which are not Latin, or which have meanings in Latin which differ from their English meanings? Such words as "sera," "sanatoria," "curricula," and so on, simply show an ignorance of the Latin language, and should be shunned.

We cannot all write with the noble diction and surpassing grace of Lord Macaulay, but we should strive to express our thoughts clearly and with due observance of the rules of grammar. Mention of Macaulay's name tempts me to quote a passage from that master of English, in which he describes the death of Queen Mary from small-pox in the year 1694. He writes:—"That disease, over which science has since achieved a succession of glorious and beneficent victories, was then the most terrible of all the ministers of death. The havoc of the plague had been far more rapid; but the plague had visited our shores only once or twice within living memory; and the small-pox was always present, filling the churchyards with corpses, tormenting with constant fears all whom it had not yet stricken, leaving on those whose lives it spared the hideous traces of its power, turning the babe into a changeling at which the mother shuddered, and making the eyes and cheeks of the betrothed maiden objects of horror to the lover. Towards the end of the year 1694, this pestilence was more than usually severe. At length the infection spread to the palace, and reached the young and blooming Queen. She received the intimation of her danger with true greatness of soul. She gave orders that every lady of her bedchamber, every maid of honour, nay, every menial servant, who had not had the small-pox should instantly leave Kensington House. She locked herself up during a short time in her closet, burned some papers, arranged others, and then calmly waited her fate."

It is seldom that a disease receives such literary treatment as small-pox does at the hands of Lord Macaulay in the passage I have just quoted. And yet there have been and are masters of English in the ranks of the medical profession. What more graphic descriptions of disease exist than those to be met with in the works of Thomas Watson, Robert James Graves, William Stokes, James Paget, Charles Murchison, or Charles Hilton Fagge—to say nothing of living medical writers? Take such men for your examples, and strain every effort in your future career to uphold the glorious traditions of medicine as a learned as well as a beneficent profession.

Prescription writing is also sadly neglected nowadays. One sometimes is inclined to be angry on reading the attempts which even certain qualified practitioners make at producing a prescription in Latin. Practise prescription writing in unabbreviated Latin if you will, but it may be better for the compounder and for the patient if the directions—or what is technically called the "signatures"—are written legibly in English: we shall then escape such monstrosities as "Cap. coch. mag. p. cib. t. i. d.," and the like.

During the Third Dynasty of Egypt, about the year 3500 B.C., there lived a learned physician (probably a priest of Ra, the sun-god), whose eminence was such that in the course of ages he was deified and became for later generations the special god of medicine. In a learned Harveian Oration on Ancient Egyptian Medicine, delivered before the Royal College of Physicians of London, on June 21st, 1904, Dr. Richard Caton, of Liverpool, gives us the name and tells us the story of this physician of the olden time. His name is I-em-hotep, meaning "He who cometh in peace." He is described as "the good physician of gods and men, a kind and merciful god, assuaging the sufferings of those in pain, healing the diseases of men, giving peaceful sleep to the restless and suffering." What more splendid character for a physician can we desire! It must have been some such physician that the writer of Ecclesiasticus had in mind when he wrote: "Honour a physician according to thy need of him with the honours due unto him; for verily the Lord hath created him. For from the Most High cometh healing; and from the king he shall receive a gift. The skill of the physician shall lift up his head; and in the sight of great men he shall be admired." . . . "There is a time when in their very hands is the issue for good. For they also shall beseech the Lord, that He may prosper them in giving relief and in healing for the maintenance of life."

It is, alas, too true that often our unsparing and self-denying efforts to save life are all in vain, and bereavement and sorrow enter as the physician leaves some stricken home. Yet we physicians also know what bereavement and sorrow mean—

"Lo! some we loved, the loveliest and the best
That Time and Fate of all their vintage prest,
Have drunk their cup a round or two before,
And one by one crept silently to rest."
Omar Khayyam (A.D. 1123).

In this address I have sought to teach you that Knowledge and Experience are the two pillars which support the Temple of Æsculapius—that is to say, the Healing Art. Seek to acquire both—

"Who loves not Knowledge? Who shall rail
Against her beauty? May she mix
With men and prosper! Who shall fix
Her pillars? Let her work prevail."
Tennyson: *In Memoriam*, cxiii.

Experience—here in the hospital wards you will by diligent searching find it, even at a time when the responsibility of your attendance on the sick is shared—nay, borne by your teachers. Lay fast hold on Opportunity and you will never regret it.

Standing, fellow students, as we do on the threshold of a new Session, in my colleagues' names and my own, I bid you one and all a hearty welcome to our wards. May the coming months be a time of earnest, hearty work; and, when their sands run out, may the teachers and the taught be knit together in the silken bonds of a life-long friendship!

The Therapeutical Society.

The annual meeting will be held at the Apothecaries' Hall, on Tuesday, October 24th, at 4 p.m. The officers will be elected, and Dr. French will read a paper on the "Therapeutical Aspects of the Congress of Hygiene;" Mr. T. R. Elliott, one on "The Action of Adrenalin Chloride;" and Dr. Steele and Dr. Plant one on "Adrenalin Chloride in the Treatment of Serous Effusions."

THE IRISH MEDICAL ASSOCIATION: ITS RE-ORGANISATION AND ITS FUTURE. (a)

By RICHARD MARLAY BLAKE, M.R.C.P.I.;
Vice-President, Irish Poor-law Association.

V.

The Irish Medical Association has a history of sixty odd years to look back upon. After a stormy and strenuous youth it gradually fell into a state almost of decrepitude and became a mere machine to enable some Hospital Surgeon to assure his country friends from the Presidential Chair that the Codlin of this year was their friend and not the Short of last year. Incidentally it was the excuse for an annual outing, with dining and wineing galore, and occasionally it sent a deputation to the Custom House, who were politely bowed in, listened to in a politely bored manner and politely bowed out again. No wonder we isolated country units lost heart, dropped away from it, and submitted tamely, unresistingly, to the hardships and indignities heaped upon us. When a heroic doctor here and there gladly laid down his life for the poor and lowly, if news was slack the papers made useful copy of his heroism. When worn out with years and toil, penniless and heartbroken, some poor wretch hurried himself from a well-nigh intolerable position to a suicide's unhonoured grave the public wondered, perhaps pitied, and passed on.

The first time within my memory that any real hope of betterment appeared was when Mahon and his Mayo friends gave us something to hope for, something to fight for. Enniskillen laid down, in a tentative way, the plan of campaign, the method and the mode of fighting. It was by no means perfect, but anything gained so far has been gained by it. Where it was intelligently used and where the county branch was united and unselfish, as in Wexford and Louth, it came very near to victory: its very defeats were moral victories. Let me remind your readers that we of Louth kept the Drumconrath Dispensary vacant for over two years, and, indeed, it was never filled. The Local Government Board had to strain the law, flout public opinion and with cynical disregard of the interest of God's poor—the safeguarding of whose health and comfort is the *raison d'être* of their existence—before they carried their point and broke up the district. The result is seen in the continual protests from the Ardee Guardians, complaining of the intolerable state of affairs existing. Three inquests were held on the victims of accidents whom the large extent of the districts prevented the medical officers from reaching in time to save life. Surely a verdict of homicide against the L.G.B. would have been justifiable.

I shall not enter into Surgeon-General Evatt's incursions and alarms and the storm in a tea-cup that followed on this most Superior Person's patronising English method of teaching his Irish Granny how to suck eggs. At all events it cleared the air and led to the appointment of a committee composed of some of the best business men in our Association to find out the best method of re-organising. The net result was a Majority Report, to which in fact the minority agreed, except in regard to a few minor points. They have since, I regret to see, in a most ill-advised manner, attempted to upset the decision solemnly come to and have apparently captured the Editor, and with him the *Journal*, of the I.M.A. This state of affairs cannot last long. The Majority Report holds the field, and I for one shall endeavour to see that it is loyally acted upon.

The plan adopted of recent years was to have thirty-two county councillors and forty odd general councillors. The body so formed met quarterly, for the transaction of business ostensibly; but really in my experience it was a sort of debating society conducted in a loose, irregular, and occasionally somewhat disorderly manner. The effect was that men hurried away to catch trains and the real business was done by the committee of council. This led inevitably up to the conclusion come to by the re-organisation committee to replace them by a small body not to exceed twenty-five, who should meet monthly and have their out-of-pocket travelling expenses paid. That they be elected by all the members of the Association directly, and be responsible to general meeting and be the executive. All sorts of plans were honestly striven for to group electoral centres, but were found impracticable. Under the old plan some counties were much over-represented, for instance, Louth had three, Wexford three, and some only one. Until a better and more perfect plan is put forward, I am strongly of opinion that the Majority Report holds the field. Now as to the policy to be adopted I believe it should be a fighting one and in brief what I think it should be I propose to tell you.

I look upon the question of re-organisation as a minor one. For me any stick is good enough to beat a dog with, provided it be heavy and thorny enough, and that the wielders have stout hearts and strong hands.

Have we such a weapon handy, and what is it? Yes, I advocate that a representative deputation of our body, accompanied by the Provost of T.C.D., and the Presidents of the Royal College, *en grand tenue*, should wait upon the L.G.B., and present them with our ultimatum. If our conditions, or the more essential ones of them, be not granted we should give them due notice that on an appointed day we intend to resign in a body. The poor need not be in the least inconvenienced, for we could offer to act as temporary medical officers at a suitable remuneration pending a settlement. As we perform *quasi* public duties for the State it is not too much to expect that the funds required should come from Imperial and not local sources. The ratepayer is willing enough to see us properly paid and pensioned, but he simply cannot afford to do it himself. We shall thus gain the support of the public and the members of Parliament of all parties who represent them.

As to our demands, they should be—

1. A salary commencing at, say, £150, rising by annual increments to £300; vaccination and sundries not to be included. In all cases to be retrospective.
2. After thirty years' service or at sixty years of age, optional retirement with Civil Service scale pension. After sixty-five years compulsory retirement.
3. Sick leave as at present save that half be

(a) Being the fifth of a series of articles specially communicated to the columns of the Medical Press and Circular by prominent members of the Irish Medical Association.

recouped to local rates, which at present is not the case.

4. A free post-graduate course every five years.

5. The medical officership of health to be held by a non-practising doctor chosen by competitive examination from the dispensary and union doctors. He could also be county analyst.

6. That L.G.B. Inspectors be taken from our ranks and not as at present from the militia, the volunteers, and the younger sons of the impecunious nobility, clergy, and gentry. No doubt the L.G.B. trembling at the frown of their masters, the Treasury clerks, would bluster for a bit but would eventually climb down and that quickly. Let us have done with these battles of the kites and crows, take our courage in our hands, and the day will be won.

A NOTE ON TOXÆMIA.

By ALEXANDER DUKE, M.D.

To Toxic conditions of the blood we may fairly ascribe most of the chronic illnesses of the age. Produced in the first instance by injudicious feeding in infancy, over-feeding in youth, a life of luxury, not sufficient exercise of body or mind, insufficient sleep, alcoholic excess, the palate gratified at the expense of the digestive organs, proving the truth of the old saying, "How many dig their graves with their teeth."

Blood poisoning manifests itself in various ways, and is often unrecognised as such, being known by the convenient terms rheumatism, gout, influenza, bronchitis, asthma, &c., *all due to a want of balance between the secretory and excretory organs.* What can be more likely than that excessive feeding in infancy and youth, by over-taxing immature organs, should sow the seeds of disease manifested too plainly later on in life.

Over-feeding with meat diet in early youth (under the delusion it will strengthen and fortify the body) produces the very opposite effect, which is first shown by early decay of teeth, sluggishness of brain power, and general lethargy.

The decay of teeth alone helps, both by failure in mastication and by their carious condition, to induce toxic condition of the blood—if not in youth, certainly later on. The quantity of food consumed by the great bulk of the population, particularly those who can afford to please their palates, being utterly out of proportion to the amount of exercise taken, more especially in these days of bicycles, motor-cars, &c., &c. (and also with regard to the mental work done), result in obesity, constipation, and indigestion—the first symptoms to give warning—which, if not attended to, lead on to more serious conditions so common—gout, rheumatism, &c.—for the treatment of which many crowd the health resorts and hydropathic establishments. Temporary relief is no doubt obtained, but many of those benefited return to their former way of living with dire results eventually.

Far better to allow the stomach to crave for supplies, than to overload the system or endeavour to produce a false appetite by bitters, &c., so that the palate can be pleased without thought of the ultimate result. The usual "spring cleaning" of their bodies by "drinking the waters," now so fashionable among those who can afford it, can only give temporary relief. The real cause of the symptoms for which they seek a cure is perhaps left untouched; and the same remedy is sought for year after year till Nature refuses to respond, the sufferer becoming prematurely old, and eventually a victim to his own over-indulgence. Surely, as some one has wisely said, "For every indiscretion of Nature she is certain to enact a heavy penalty."

Out-Patient Departments.

ROYAL HOSPITAL FOR SICK CHILDREN AND WOMEN, BRISTOL.

Medical Cases under the Care of Carey Coombs, M.D., B.S.Lond.,

Physician to Out-Patients to the Hospital; Curator of the Museum, Bristol General Hospital.

Case I.—A baby, æt. 6 weeks, was brought here because of deficiency of movement in the left arm, the forearm more particularly. This has been noticed for the past ten days or so, and seems to be gradually increasing. The birth was an easy one, forceps not being needed, and except for a cold in the head with spots on the face and buttocks, there has been nothing much amiss with the child, who is plump and well-favoured. The limb itself is well-rounded but a trifle flabby, and hangs limply at the child's side; movements executed by the forearm muscles are restricted, while those about the shoulder-joint are more nearly normal. Two points of great importance are, that the child cries when the arm is handled, and that there is a slight but definite swelling about the lower end of the radius on the affected side, very like the expansion of a rickety growing-line, but softer. There is neither displacement nor abnormal mobility, and apart from a doubtful thickening of the lower end of the right tibia, the skeleton is otherwise unaffected.

The possible causes of weakness in an infant's arm may be headed (*a*) ante-natal, (*b*) natal, (*c*) post-natal. Two facts help to exclude an ante-natal lesion—the limb is not small, and, what is a less positive piece of evidence, no weakness had been apparent during the first four weeks of life. The latter point, though discounted by the difficulty of studying the movements of a new-born infant, helps one to set aside birth-palsies, both central and peripheral; these are, further, extremely unlikely to be brought about in the course of a normal delivery without instruments. Of post-natal causes, those which most readily occur to the mind are acute anterior poliomyelitis, the cerebral lesions that cause infantile hemiplegia, and disease or injury of bones or joints. The first two are not indicated by any positive fact; there is neither absolute flaccidity nor any spasticity, and there has been no acute illness. The one positive fact is that there is a swelling about the osteogenetic zone of the lower end of the radius corresponding with area of the limited movement, which seems to be tender.

There is yet a further question to be answered: What is the nature of the bony disease? Rickets and scurvy can be overlooked in a child æt. 6 weeks, colide tuberculosis is not likely; there remains hereditary syphilis, which produces a para-epiphysitis often characterised by paresis of the affected limb or limbs—the so-called "syphilitic pseudo-paralysis" of Parrot. The child looks so well that he seems scarcely likely to be a syphilitic, and the most careful inquiry fails to get any history of syphilis in parents or other children. However, there are spots on both sides of the mouth, which have been there a week or two. Those on the right side are linear fissures, radiating from the angle of the mouth. The hair is long, dark, and fine (that this is often so in syphilitics was, I believe, first pointed out by Dr. W. S. Colman); the soles of the feet are pink and peeling; about the anus are several condylomata in the midst of an erythema, which extends down the backs and inner sides of both thighs. Add to this the persistent thick discharge from the nose, which has been noticed for a week or more, and there can be no doubt that the child is syphilitic.

In many of these cases of syphilis of the osteogenetic zone, the diseased area breaks down still further and even forms pus under the influence of cocci. The epiphysis is completely severed from the diaphysis, and the paresis is even more definite. Luckily, however, this child is improving rapidly on mercury by the mouth and through the skin, with the help of a splint to the forearm. So sure is this improvement that it is possible to discard the splint more or less already, for the swelling of the forearm is smaller and the movements are greater. Henoch, Scherer, and others have shown that in some instances, at any rate, the cause of the paresis is neuritis, and Scherer goes so far as to say that it is always so—that the bone lesion is not responsible for the muscular feebleness. This is surely an extreme view, as the connection between syphilitic para-epiphysitis and limitation of movement is too close to be explained away by calling it a frequent coincidence.

Case II.—A woman, æt. 39, who has ever since the age of 7 suffered from attacks of migraine, though lately she has been troubled more often than before. Her attacks are peculiar in several respects, but they are exactly similar to those experienced by her mother. As far as can be found by inquiry, there is no other expression of the "neuropathic heredity" in herself or in any other member of the family. The prodromal stage of a migranous attack usually consists in some disturbance of the special sense. In this instance, however, it is the general tactile sense that suffers. The attack begins with a peculiar numb feeling in the hand or foot (more often the foot), which spreads over the corresponding half of the body till in half an hour or so exactly one-half of her body feels numb and anæsthetic to touch. So precise is this hemianæsthesia that the lips and tongue are accurately divided at the middle line into a sensitive and an insensitive half. She can give no information as to appreciation of heat and pain, and there is no paralysis. The right side is affected more often than the left. As soon as the numbness has spread over half the body, headache, or, rather, head pain begins, always on the same side as the anæsthesia, just above the eye. It is very severe, and spreads back as far as the vertex, finally affecting both sides, though the occipital region is spared. Meanwhile, sensation in the affected area quickly returns. Just after the headache has done its worst, and when it is beginning to get better, streaks of white light appear and disturb her vision, which finally goes completely in both eyes for the time being. The whole attack lasts two or three days; she is quite unfit for work, and usually vomits once or twice. Her teeth are in a very bad state, and she is dyspeptic; she also complains that her eyes are tired by her occupation (that of a tailoress).

This case, is, of course, unexceptional apart from the initial stage; but the repetition of a train of sensory disturbances, always marching in a certain definite order, affords obvious support to Liveing's suggestion that migraine is the sensory analogue of the motor disturbance, epilepsy. I have not hitherto met with a case in which there has been so widespread a derangement of the afferent apparatus, the actual seat of the storm being most likely the cerebral cortex.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

Meeting held Friday, October 13th, 1905.

The President, Mr. Clutton, in the Chair.

Dr. David Newman gave a demonstration of the CYSTOSCOPIC APPEARANCES IN RENAL DISEASE. He showed, by means of a specially constructed opaque projector, the morbid aspects of the urinary bladder with special reference to the cystoscopic appearances presented by the mucous membrane of the trigone and the orifices of the ureters in certain diseases of the kidney. He described his first electric cystoscope, which is still armed with the first electric lamp introduced (January, 1883) into a human bladder. He then described his modern cystoscope, which fulfils the following requirements:—(1) Comparatively small lumen of the stem so that the instrument may be introduced without injury to the urethra or to the neck of the bladder; (2) large field of vision and a clear view; (3) easy means of clearing the field, should it become obscure, without removing the stem of the instrument from the bladder; (4) good illumination without danger of scalding the mucous membrane of the bladder; (5) ease in sterilising the instrument; (6) facility in emptying the bladder, should there be clamant call to urinate, without necessitating the removal of the cystoscope; and (7) ability to demonstrate to a second observer the object seen; (8) means of steadying the instrument while an examination is being made, of fixing the prism of the cystoscope at any particular point, and of defining clearly the position of the lesion. Among the morbid changes demonstrated were the following:—Recent tuberculous deposit close to the neck of the bladder; encysted stone in which, without the assistance of the cystoscope, the calculus would probably have escaped observation; papilloma of the bladder; sarcoma of the bladder. calculus impacted in the ureter, with the appearance of the ureter orifice while the stone was impacted and after it had escaped: calculus which has passed through the muscular wall of the bladder and pushed the mucous membrane in front of it so as to present the appearance of a tumour; recent ascending ureteritis from a case of acute septic infection of the bladder; a series of shoots escaping from the ureter, demonstrating the escape of blood, stone, urine, and blood clots. He pointed out that: (1) When one ureter orifice is altered, while the other is normal, the renal lesion is on the side of the morbid ureter. (2) When the urinary shoots are more frequent on one side than on the other—(*a*) greater functional activity is indicated by the shoots being uniform in size and regular in rhythm; (*b*) undue irritation of the kidney is to be inferred when the shoots, while more frequent than normal, are irregular in rhythm, unequal, and small in size; (*c*) stricture, stone, or chronic ureteritis should be suspected when the shoots are distorted in form, or irregular in amount. (3) When the urine does not escape in distinct jets—(*a*) dilatation of the ureter without paralysis of the sphincter is indicated when the urine dribbles into the bladder at intervals; (*b*) destruction of the sphincter action is shown by the urine flowing into the bladder almost continually. (4) The character of the morbid fluids escaping from the ureter, or of clots, &c., occupying the opening, denotes the morbid changes taking place in the corresponding kidney. (5) The deformity of the orifice also indicates the character of the renal disease—(*a*) pin-head contraction (chronic inflammation or impacted calculus); (*b*) elongated and distorted (distension of renal pelvis or infected nephritis); (*c*) swollen or pouting (prolonged but not acute inflammation of renal parenchyma); (*d*) dilated (advanced tuberculous or calculous pyonephrosis; (*e*) U-shaped (significance doubtful—usually denotes prolonged irritation of renal pelvis).

TUBERCULOSIS IN A DIVERTICULUM OF THE BLADDER FOUND IN AN INGUINAL HERNIA.

Mr. Edred M. Corner and Mr. Cecil W. Rowntree reported the case of a boy, æt. 18 months, who was operated on for what was diagnosed as an irreducible inguinal hernia. No peritoneal sac was found, but a diverticulum of the bladder containing a few drachms of urine was excised. The bladder and the inguinal canal were sutured; the wound healing by first intention. Two months later the boy was re-admitted to the Children's Hospital, Great Ormond Street, for tuberculous peritonitis. Laparotomy was done, a large quantity of fluid evacuated, and the viscera found to be covered with miliary tubercles. From this date the boy steadily improved, and is now very well, a year after the operation for hernia. The diverticulum was two inches long and lined in part with a smooth membrane, like that of the bladder. At the lower pole it was enormously thickened and resembled an os uteri. Microscopical examination revealed the presence of tubercles.

Mr. **Clutton** remarked that he had several times seen the bladder in hernia operations, but never a case similar to this unique one. He remembered seeing miliary tuberculosis of a sac once, the operation being followed by tuberculous peritonitis. In the present case he thought that the diverticulum might have been produced through the tuberculous disease.

Mr. **Brook** had seen a case in which hæmaturia followed on operation for radical cure. At a subsequent operation it was shown that a portion of the bladder had been excised.

Mr. **Corner**, in reply to Mr. Clutton, said that the lump had been present since birth, this making it improbable that it was secondary to tuberculous disease.

MEDICAL SOCIETY OF LONDON.

General Meeting held on October 9th.

Dr. C. E. **Beevor**, Vice-President, in the Chair.

After the annual report of the council had been read and adopted, votes of thanks to the retiring President, Mr. John Langton, and the retiring Secretary, Mr. H. J. Waring, had been passed,

The incoming President, Sir **Lauder Brunton**, took the chair and delivered his Inaugural Address.

Dr. St. **Clair Thomson** read a paper on the

CEREBRAL AND OPHTHALMIC COMPLICATIONS IN THREE CASES OF SPHENOIDAL SINUSITIS.

The frequent origin of intracranial complications from suppuration of the ear was, he remarked, now generally appreciated, but a similar association had not yet been fully established between the brain and the nose. An analysis of 9,000 necropsies at Guy's Hospital revealed 57 cases of intracranial mischief from ear disease, but Dr. G. Newton Pitt could only discover one case of cerebral abscess due to nasal suppuration. But in Dr. Thomson's view, if the accessory sinuses were more systematically examined in cases of intracranial inflammation, the former would be found a much more frequent source of the latter than was generally supposed. In fact, one observer who had systematically examined the accessory cavities in all necropsies had found suppuration in the nasal cavities in 30 per cent. Of the accessory sinuses the sphenoidal cavity seemed to be the most frequent source of cerebral trouble. Three cases of sphenoidal sinusitis were then narrated, two of them being followed by necropsies. One of the cases was found to be an infection of the meninges from a long latent chronic sinusitis. In another case, that of a girl, æt. 16, the most prominent symptoms were double proptosis and chemosis. She had never had any suppurative or other discharge from the nose. Under an anæsthetic a large quantity of pus was evacuated from the nose and also from the orbits, but the patient eventually died. At the necropsy the cavernous and other venous sinuses were found to be the seat of infective thrombi. Dr. Thomson discussed the symptoms of inflammation of the sphenoidal sinus, its causes, the bacteria found in the infective fluids, and its treatment. The necessity for examination of the sinuses as a routine practice in such cases was insisted on, complete and adequate drainage emphasised, and the best route for the drainage to be effected discussed.

Dr. **Beevor** referred to the case of a girl who was taken to the National Hospital for the Paralysed and Epileptic in a comatose condition. The diagnosis of sphenoidal sinus disease was not made during life. The nasal cavity had not been examined.

Dr. **Herbert Tilley** congratulated Dr. Thomson on directing attention to these important matters. The thorough examination of nasal cavities was not very easy. The symptoms were often surprisingly few. Even when headache was complained of it was usually in the occipital region. A small bead of suppuration might often be seen pulsating in the roof of the nose on to the front wall of the sphenoid. It was very easy to open the front wall of the sphenoidal sinus, but extremely difficult to keep it open.

Dr. R. H. **Scanes Spicer** referred to the methods of examining the sphenoidal sinus. In doubtful cases a thorough examination should be made under an anæsthetic by passing the finger into the posterior nares to aid in the direction of the probe or catheter.

Dr. **Dundas Grant** complimented Dr. St. Clair Thomson most highly on his valuable communication. In Dr. Thomson's cases, the *post-mortem* examination showed unquestionably that the sinus was diseased; but in reports in which it was merely stated that purulent fluid was found in the sphenoidal sinus, this fluid was sometimes secreted in other parts of the nose and not in the sphenoidal sinus itself. It had been distinctly proved that when the head was thrown back, as in the lying posture, fluids gravitated into the sphenoidal sinus. It was, therefore, probable that *post-mortem* examinations gave the percentage of disease of the sphenoidal sinus as very much higher than it really was. He agreed as to the uncertainty of the localisation of pain, and, in any case, as far as regards pain in the frontal region, it might arise from disease of the frontal or of the maxillary or of the sphenoidal sinus. He agreed with Dr. Tilley as to the great difficulty in keeping the opening patent. He advocated removal of the floor of the sinus so as practically to annihilate the sinus, but the bone there was, as a rule, so thick that instruments of much greater strength than those generally used for the opening of the sphenoidal sinus were required. Another plan was to tear the outer part of the anterior wall of the sphenoidal sinus directly forwards into the posterior ethmoidal cells which lay in front and concealed the lateral half of the sphenoidal sinus.

Mr. W. H. H. **Jessop** had noticed proptosis in all the cases which he had observed and he would like to know whether the protrusion of the eyes was directly forward or forward and downward in direction.

Dr. **Thomson** having replied, the meeting adjourned.

FOLKESTONE MEDICAL SOCIETY.

Meeting held October 6th, 1905.

Dr. **Lennox Wainwright** read a paper on—

EARLY TREATMENT IN OTITIS MEDIA.

The importance of early diagnosis in all doubtful cases of infants and young children, he remarked, was best determined by giving an anæsthetic and examining. Early dry heat he had found useful when applied over the mastoid and external ear in the form of hot dry wool, Japanese muff warmer; electric light in an asbestos cone and hot bottles. Cold he had found useful in a few cases only. To relieve pain and hyperæmia adrenalin, 1 in 2,000, with cocaine, 4 per cent., applied to the tympanum, followed by air pressure douche through nostril would often clear up simple cases; calomel as a purge, counter-irritants, mustard-leaves, leeching in front of tragus and behind mastoid were also useful. Compressed nebulised vapour through the nostril should be in a steady stream and not intermittent, as in Politzer bag; air should be medicated; he preferred it oxygenated by means of Dr. George Stoker's bag. In cases of severe glandular infection from scarlet fever and tonsillitis he used antistreptococcus serum, 5 to 10 cc. is most useful. Where the membrane is bulging and pain persisted, he generally performed paracentesis; exhausting gently with Siegle's speculum or suction syringe. It was moreover, necessary to disinfect the naso-pharynx, and, where safe, to pass a catheter and inject medicated air or oxygentated vapour. Passing a catheter is always a moot point, but it often relieved an obstructed tube and saved the case. But the use of oxygenated vapour, or medicated vapour, without a catheter would do no harm in the naso-pharynx, and it frequently proved most successful. In all cases careful cleansing of the naso-pharynx was of the first importance before using any instrument—for the majority of cases instruments were not needed, simple treatment being sufficient. In more severe cases paracentesis and drainage, on sound surgical lines, was the only course open. In cases of persistent bloody discharge and parietal pain a simple mastoid operation is generally needed, and as delays are dangerous the operation preferred should have for its object the saving of the middle ear.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, October 15th, 1905.

Dilatation of the Stomach.

In cases where there exists hyper-acidity alkalines are indicated :—

Bicarb. of soda, 10 grs.
Calcined magnesia, 10 grs.
S.N. of bismuth, 5 grs.
Prepared chalk, 5 grs.

For one wafer, to be taken every two, three, or four hours, according to the degree of hyper-secretion.

In this way a marked sedation of all the painful sensations and rapid improvement in the general condition may be observed.

Against constipation so frequently accompanying dilatation of the stomach :—

Phosphate of soda, 1 drachm ;
Bicarb. of soda, 1 drachm ;
Sulphate of soda, 1 drachm.

To be dissolved in a quart bottle of water. A glassful of this solution taken fasting in the morning constitutes an effective laxative.

Cancer of the Breast.

There exist only two kinds of cancer—encephaloid and scirrhous. Two other affections, says Prof. Manclaire, comprised in the group of cancers, should be deducted ; they are sarcoma and cysts.

The encephaloid cancer is at the outset at least insidious and painless ; the patients think nothing of it and allow the tumour to grow. But in the meantime it progresses both inwardly and outwardly. The adherence contracted with the skin produces the classical orange peel aspect. Soon the nipple retracts and ganglia show themselves behind the pectoris major and in the axilla ; the skin ulcerates.

It is of paramount importance to diagnose at the earliest period possible such a grave affection. The best method for examining the gland is to place the hand flatly over it and press it back on the ribs ; by this means the tumour can be properly outlined. The duration of the malady left to itself is from eighteen months to two years.

Scirrhous cancer is met with in women who have attained a certain age, while the former is observed in patients under fifty.

Scirrhus is a small, hard tumour producing atrophy of the gland, and lasts for ten or fifteen years. Sometimes it takes the form of a cuirasse embracing the thorax as in a vice, and finally carries off the patient by asphyxia.

Both these affections should be distinguished from many others as cutaneous epithelioma, chancre of the nipple, syphilitic gummæ. All of these, moreover, can be recognised by a little attention. However, there may be observed certain tumours which have been frequently confounded with cancer, the principal of which are cold abscess and tuberculous disease of the breast. The former is encysted, rounded and fluctuating, while the latter is characterised by tuberculous granulations disseminated in the gland. In both fistulæ are formed, giving issue to sanious pus.

The cystic disease of the breast described in France by Réclus is a bilateral tumour, while bilateral encephaloid cancer is very rare. The cystic malady presents the sensation of a series of grains of shot infiltrated throughout the gland ; no ganglia are observed in the axilla. The malady is stationary and benign. Chronic mammitis has been frequently mistaken for cancer, and according to M. Manclaire, many cancers operated on without relapse were cases of chronic mammitis. The affection, like encephaloid cancer, comes on towards the menopause and is observed especially in women who have suffered previously from abscess of the breast. Adenoma of the breast is easy to diagnose ; it consists in a small tumour appearing in young women ; it is encysted and painful ; it neither adheres to the skin nor produces any change in the nipple.

Sarcoma is readily distinguished by its enormous mass with cutaneous veins running over it.

The prognosis of cancers is subordinate to their variety ; scirrhus can last twenty years, but it can also degenerate or take on the form of a cuirasse, which is still more grave. Encephaloid cancer is generally fatal within the space of two years.

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, October 15th, 1905.

Medical Officers of Health.

It may interest your readers to learn what amount of responsibility some of our cities place on the shoulders of their medical officers. The city of Cologne has recently appointed its former Kreisarzt Medical Assessor to the local magistracy, and in doing so has tabulated the direction in which he will be expected to show activity —(1) Hygienic initiative in all departments of city government ; (2) dwelling-house and health regulations, the pronouncement of the necessary professional opinion, with chairmanship of the Health Committee, deputy chairmanship of the Commission for regulation and inspection of dwelling-houses ; (3) vaccination matters ; (4) school hygiene, infectious diseases among school children, teachers, and school medical officers ; (5) professional opinion as to punishment by imprisonment, as to whether the sentence should be carried out or completed ; (6) the institution for inspection of food-stuffs ; (7) professional opinion as to school, hospital and other buildings as to their sanitary condition ; (8) membership of the Poors' Deputation, the Orphanage, the Committee for the City Hospitals, that of the Children's Hospital, the Poors' Hospital and Apotheke, the Institution for Disinfection, and the bacteriological laboratory ; (9) seat on the School Committee or Deputation ; (10) seat on the Committee for Slaughtering and Cattle matters and markets, trichina and meat inspection, food-stuffs, markets ; (11) city baths, with chairmanship of the Committee ; (12) seat on the Committee for Statistics, including medical ; (13) medical examination of officials, the newly-appointed copyists and workmen on being taken on, on leave, and on retirement. No comment is necessary ; the list speaks for itself.

Dentists and their Descriptions.

A dentist of Weimar had his plate inscribed, "Dentist, Qualified in Holland." For this description, having no German qualification, he was prosecuted twice, and acquitted each time. A third time he was prosecuted, and this time with the result that he was fined ten shillings and ordered to take down his plate, with permission to replace it with the inscription altered to "Unqualified in Germany, but qualified in Holland."

At the Medical Society Exc. Von Bergmann spoke on the

Forerunners of Cancer.

He called to mind the comparative frequency with which cancer developed on the cicatrices of burns and also the fact that there was a connection between chronic irritation and the development of malignant disease. In 1874 Paget noted the changes in the nipple that sometimes preceded cancer. Paget's disease was, however, rare. In his own klinik he had seen 1,000 cases of mammary carcinoma, but of these seven only were cases of Paget's disease. In 1875 Volkmann drew attention to cancer in paraffin workers, in whom the disease was multiple. Sweeps' cancer belonged to this category.

Then, further, psoriasis of the tongue came under consideration, an affection that had absolutely nothing to do with syphilis. Papillæ and mucous glands might remain a long time unchanged. At last, however, papillæ developed downwards, and if an atypical growth of epithelium took place carcinoma appeared in some part. A patient was shown from whom carcinoma of the tongue had been removed two and a quarter years ago, that grew in the middle of the plaques of psoriasis. Up to the present there had been no return of the disease.

Carcinoma was also known to develop on lupus cicatrices, or on fresh lupus, as well as on children with xeroderma pigmentosum (Kaposi).

Hr. Bumm spoke on

THE SURGICAL TREATMENT OF PUERPERAL SEPSIS.

He first spoke of the hopelessness of curetting or even extirpating the infected uterus, the tubes or ovaries in cases of puerperal sepsis. The idea first brought forward by Sippel, on the other hand, of ligaturing the veins in cases of septic thrombo-phlebitis in pyæmia had been too little followed up. These cases might run a very acute course, on the second or third day of childbed a rigor might come on with high fever, or the course might be subacute, the rigor coming on at intervals and the patient dying at last from exhaustion.

W. A. Freund was the first who had ligatured the veins in this disease, but without result. Later on Trendelenburg after a number of failures achieved a success. The speaker himself had at an earlier time done the operation unsuccessfully, and had now again started a fresh trial. He ligatured, according to the condition met with, either one or both spermatic or hypogastric veins. Two or three days after doing this one or two rigors took place, and the temperature fell to normal.

Five cases had been operated on during the past year in this way, two of the cases had been brought under treatment too late for it to be successful.

On examination nothing is found by the side of the uterus, and on the great blood vessels of the thigh a slight infiltration and tenderness on pressure. In order to get at the vessels he preferred the transperitoneal route as this gave a better view than the extra-peritoneal, There was only one danger in this, and that was the possibility of infecting the peritoneum if any phlebitis was present. This was not the case, however, with chronic pyæmia, for which the operation was mainly suitable.

Ligature of the veins was quite enough; to excise them was both objectless and dangerous.

Hr. Kownatzki would treat puerperal peritonitis by laparotomy and drainage. He related five cases treated successfully by Bumm by multiple incisions, followed by drainage. The incisions were made above Poupart's ligament, in the lumbar region and in Douglas's pouch. Rubber drainage tubes were inserted and the part was washed out twice daily for the first few days, but at the operation itself the abdominal cavity was neither washed out nor plugged with gauze.

Two of the cases were of pure streptococcus peritonitis; the other three were mixed. Nine cases were treated during the year, two were not operated on as they were pulseless on admission, and two died after operation.

Operation should be performed early. Exploratory puncture was useful for early diagnosis, but even where the result was negative one might properly risk an exploratory incision if the disease was thought to be a commencing peritonitis.

ARTIFICIAL TEETH AS CURATIVE AGENTS.

A compositor in Brunswick who formerly suffered constantly from stomach complaints was advised by his medical attendant to have some artifical teeth made as the four upper incisors were missing, and their absence was taken to be the probable cause of his gastric disturbances. As the local medical insurance club declines to pay for the plate, the patient applied to the city magistrate who gave judgment in the claimant's favour, on the ground that the teeth in question were a remedy. The club appealed against this decision to the Archducal Court, and the decision was again given against the club on the ground that artificial teeth were in the same category as spectacles and trusses as remedial agents.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 14th, 1905.

A PREGNANT UTERUS.

AT the Prague "Verein" Franqué demonstrated a preparation taken from a female in the last months of pregnancy. The patient suffered from a severe form of osteomalacia almost closing the pelvic outlet. Approaching the period of delivery Franqué resolved to perform the Cæsarean section although the child was dead. Porro's amputation of the uterus was performed by sewing the genital canal to the parietal peritoneum. The hardened preparation shewed the entire uterus containing the fœtus in the natural position with the contractile rings and attenuated cervix.

The operation seemed to be a success, but twenty days after the woman died of multiple abscesses in the lung, the result of thrombosis having formed in the spermatic vein and uterina descendens, which appears to have become purulent and afterwards carried to the lung.

Along with preparation of the uterus and fœtus he showed others of extrauterine pregnancy three, four, and twelve weeks gone in pregnancy, which had caused fatal hæmorrhage into the abdomen. In other three cases he operated with one death. In this fatal case the water had broken sixteen hours before the diagnosis was made, as this is very difficult in such cases owing to the menses continuing at the normal period and the indefinite result of digital examination as the Fallopian tubes are greatly thickened and enlarged physiologically from the pregnancy itself.

CYTODIAGNOSIS IN CEREBRO-SPINAL FLUID.

Fischer told the members that his labours were directed towards proving the correctness of Quincke's hypothesis that lymphocytes were only found in the fluid when particular diseases are present. He finds that small-celled lymphocytes are increased in all diseases of the central nerve system, while the quantity present depends on the amount of meninges involved as well as the organic changes present in the fibrous tissue, such as progressive paralysis, tabes, arteriosclerosis of the meninges and brain. It is different when the affection is acute with a train of functional disorders such as melancholy, paranoia, hysteria, neurasthenia, alcoholism, &c., which macroscopically shows nothing abnormal to the observer in the brain or spinal cord. In these cases the fluid is clear or it may be slightly cloudy with a few leucocytes. The first group by protracted endurance may in the course of time also become clear. At this stage he presented microscopic specimens of cellular profusion in fluid taken from a case of progressive paralysis, who, after one year's illness, died.

A firm cellular infiltration of the meninges of the small cell order was met with.

To show what chronicity can do, he showed another case of progressive paralysis which had gone on for eight years where the cerebro-spinal fluid was almost normal. At the *post-mortem* there was only a hard thickening of the meninges, with fibrous tissue, but no recent inflammatory centres could be found.

CEREBRAL TUMOUR.

Pick showed a girl in whom the diagnosis pointed to a tumour in the angle between the cerebellum and the pons. She was quite blind and deaf with protrusion of the bulbi, congestion of the papilla, hemiatrophia, linbuæ paresis of the right abducens; but absence of knee reflex, headache, vomiting, walking, or any contraction of the limbs. The circumference of the cranium was 50 centimetres greater than normal, with great thickening of the cranium. The Röntgen rays confirmed this leontiasis ossium, due probably to the compression of blood at the base of the brain where the nerves emerge. Pick thought this leontiasis of the cranium had even more to do with the cause, and presumed there was a tumour in front of the cerebellum. In proof of this assumption he showed preparations taken from cases of leontiasis where cerebral tumours were present, which may orginally have been the cause of the great thickening.

He also exhibited a man, æt. 66, with pseudo-paralysis. There were no paralytic attacks and intelligence good, while there were motor aphasia amnestica and loss of papillary reflex. An interesting symptom was the loss of power to play an instrument, although he was a professional at the violin. He could hum over a melody without words after any one, but had no vocal power. This motor aphasia was complete in simple things like striking matches, which he was quite unable to perform.

PROGRESSIVE PARALYSIS.

Sträussler gave a history of a case with wild, maniacal ideas followed by intervals of melancholy. There was no disturbance of speech and the intelligence very slightly affected. There was a slight difference in the pupils but otherwise the whole of the faculties appeared to be normal. He suddenly lapsed into epileptic fits and died. During the last thirty-six hours he had fifty attacks.

The post-mortem revealed nothing but a cloudy condition of the meningites and diminution of the larger convolutions. Microscopicaly miliary gumma were found in the meninges which confirmed the syphilitic origin. One peculiarity of this case was the abscence of any trace of syphilitic deposit about the large vessels at the base of the brain, or the appearance of endarteritis as affirmed by Heubner in all such syphilitic cases.

Operating Theatres.

GUY'S HOSPITAL.

OPERATIONS FOR CHRONIC CONSTIPATION.—MR. ARBUTHNOT LANE operated on a woman, æt. 26. She was, he said, one of the first cases in which he had operated for chronic constipation nearly two years ago, by establishing communication between the divided end of the ileum and the sigmoid flexure. This operation had afforded her very great relief from most of the symptoms which are produced by constipation. She had, however, one trouble for which she sought relief, and this was the occasional accumulation of fæcal matter in the cæcum and transverse colon. This caused her some pain and required the free use of enemata for its removal. In this case Mr. Lane opened the abdomen in the middle line, separated the distal portion of the ileum, the cæcum, ascending colon, and the greater part of the transverse colon from their attachment to the abdominal wall, &c., ligatured the transverse colon at its termination and having divided it turned the ligatured end in on a purse-string suture. The patient made an uninterrupted recovery.

The same surgeon operated on another woman, æt. 29, on whom eight months before he had established continuity between the ileum and the sigmoid, and who was now complaining of symptoms similar to those manifested by the last patient. In this case he adopted precisely the same measures as in the previous one, with the same complete success. Mr. Lane said it was his experience that in a proportion of cases operated on by establishing a communication between the ileum and the sigmoid after division of the ileum, the patients occasionally complained of symptoms consequent upon a collection of fæcal material in the cæcum; in consequence of this he had, for some time divided the ileum and transverse colon at their distal extremities, having previously ligatured them and then excised the end of the ileum, the cæcum and the transverse colon. He then establishes continuity between the end of the ileum and the end of the transverse colon uniting together with a continuous suture the cut edge of the mesentery of the ileum with that of the distal segment of the transverse colon, so making a very neat procedure.

The third case illustrated Mr. Lane's last remarks very well; it was that of a woman, æt. 36, who had suffered all her life from constipation and who had arrived at a stage in the history of the disease in which she was beginning to lose flesh and strength and to show evidences of rapidly progressive degeneration in all her tissues. The intestines presented all the changes which are seen in advanced cases. The bowel was removed in the manner already described, and the end of the ileum was connected to that of the transverse colon. This case Mr. Lane said, illustrated a condition to which he had frequently called attention—namely, the fixation of the left ovary in the adhesions that had formed for the purpose of fixing the sigmoid as a straight conduit in the floor of the iliac fossa. These adhesions, he pointed out, commence at the reflection of the peritoneum from the meso-sigmoid to the iliac fossa external to it, and extend along the length of the meso-sigmoid to the sigmoid itself; this part of the bowel becomes fixed to the floor of the fossa and loses much of its peritoneal covering, while at the same time the calibre of its lumen is diminished in size and its muscle wall is decreased in thickness. This accounts for the pain and tenderness which accompany the difficult passage of the fæces through it. Mr. Lane said that although he had operated on a number of adults in this manner he had only lost one patient, and she was so exhausted by the prolonged toxæmia that the chances of her surviving the operation were very small indeed. Still it offered her her only chance of recovery, and she accepted it with all its obvious risks. This patient just operated upon made an uninterrupted recovery, not even being sick once after the operation.

OPERATION FOR SIMPLE FRACTURE OF THE RADIUS AND ULNA.—The same surgeon operated on a boy, æt. 15, who, a fortnight previously had sustained a transverse fracture of the radius and ulna in the upper part of the middle third of each. When the swelling had gone down it became apparent from the deformity presented that the fragments were in a very bad position. This was fully borne out by the radiograph, the fragments being seen to overlap very considerably. Traction did not influence their relationship in the slightest. Mr. Lane cut down on the ulna at the seat of fracture and found that the fragments overlapped to the extent of three-fourths of an inch. The ends of the fragments were freed from the surrounding soft parts and very forcible traction was exerted upon the hand and arm. This alone failed to produce any result; aided, however, by the use of forceps and elevators the fragments were got into accurate apposition and were retained in that relationship by means of a staple. As the ends of the fragments had become somewhat softened Mr. Lane did not think it advisable to interfere at that stage with the fracture of the radius for fear of displacing the ulnar junction. He hoped that the force which had been employed to overcome the overlapping of the ulnar fragments would have produced some considerable reduction of the displacement of the radial fragments. Should this not be the case as he thought it was he would he said deal with it later, when the ulnar fracture had consolidated sufficiently.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, OCTOBER 18, 1905.

STATE REGULATION OF IMMORALITY.

The thirteenth annual meeting of the International Abolitionist Federation has just been held at Neuchatel, and was largely attended. The object of the Federation is to prevail upon the Governments of those countries in which regulations are in force for the inspection and suppression of prostitutes, to abolish such control over them and their traffic, except in so far as the rules of public decency are violated. The subject in whatever way it is approached is an unpleasant one, but of its vast importance to the health of nations there can be but one opinion among medical men. Indeed, there is no other class in the community that is in a position to judge of the magnitude of misery and disease caused by indiscriminate sexual connection, and it is only from medical men that advice on the prevalence of and the damage caused by venereal diseases can be sought. No statistics beyond these of the Army and Navy are available for the formation of an estimate of the extent of these diseases among men, and though from the peculiar conditions of their circumstances there is a certain amount of selection against these classes, there can be but little doubt that civilians of similar age hardly suffer much less than their military and naval brethren. What these figures amount to is to be seen in the annual reports on the health of the two services, and they furnish sufficiently appalling evidence of prevalence of venereal maladies. It cannot be too often or too strongly pointed out that the punishment for sins against chastity is not confined to the individual, but that it is extended to innocent women and helpless children in a manner that might touch the pity of the sternest purist who sees only a Divine retribution in the suffering of the sinner himself. Looked at apart from the misery caused in the home, the question has a wide and crucial bearing on the health and efficiency of the nation. Infection with syphilis under modern conditions causes but little immediate inconvenience or discomfort, but the real stress comes in the shattered constitution and early death of many citizens of high value to the State, in the loss by abortion of a numerous childhood, and in the ill-health and often premature death of such as survive. Gonorrhœa, too, apart from the life-long suffering it entails on a host of wives, is a fruitful—probably the most fruitful—source of sterility, and annually robs the State of nearly as many children as are "prevented" by other means. These facts are the merest commonplaces of the doctor's daily experience, but it is astonishing how little they are known or realised by the class who are most eager for "free trade" in immorality. For that indeed is what the withdrawal of State regulation amounts to. No country has ever yet devised a plan for making illicit intercourse a misdemeanour punishable by law, provided it be not obtrusively carried out, and it is much to be doubted if, while men and women continue to be made of flesh and blood, a law of the kind would stand a chance of being anything but a by-word. The only alternative is between regulation and unregulated intercourse, aided in both cases by moral and religious education. The formidable argument of the abolitionists lies in the weakening influence which apparent connivance at immorality on the part of the State has on the education of the young, and it is useless to deny that this argument is worthy of full weight in any measure that is proposed. The system that prevails in France and other countries on the Continent, by which prostitution is a regularly licensed and recognised vocation, undoubtedly violates good morals, and by apparently lending the cachet of authority to immorality may indirectly conduce to the very evil that it seeks to restrain. It is not therefore surprising to hear that the system is likely to be abolished in the near future. An extra-Parliamentary Commission appointed by the Minister for the Interior has been sitting to inquire into the operation and effects of the system as carried on in France, and it has just reported in favour of abolition. Among others the report has been signed by Dr. Gauchet, Professor of Syphilography at the University of Paris, and M. Bulot, the Procureur-General. The French system has certainly not been a success. The unfortunate denizens of the licensed houses have not been of a sufficiently attractive class to draw the bulk of pleasure-seekers, and though it has proved fairly easy by medical inspection to recognise early disease and to quarantine the subject, the difficulty in securing any marked diminution in venereal complaints has lain in the vast number of irregular practitioners who cannot be subjected to control and whosecure the bulk of the patronage. The dissemination of disease by this class has been nearly as free and widespread as in our own country. No system of venereal disease prevention has yet proved satisfactory, and the difficulties attending any one such are peculiarly great. We are agreed with the abolitionists that no plan should be accepted that appears to encourage illicit intercourse, both from the moral and the utilitarian point of view, but we do think that no stone should be left unturned to minimise, and if it were possible extirpate, the venereal diseases that work such ruin and havoc throughout the land. The simplest plan would seem to be one whereby the medical officer of health should be given statutory power to isolate—and if necessary treat in special institutions—all cases of venereal diseases in an infectious stage that were brought to his notice, an obligation to notify privately being laid on all practitioners. It could not be pretended that such a system would wholly eradicate venereal disease, but it would tend to remove obviously diseased persons from infecting others broadcast, and would in practice confine itself to the treatment of prostitutes. Many delicate situations would doubtless be created, but with due safeguards these might be reduced to a minimum, and eventually such a regulation would probably meet with as little friction as the present notification acts. At any rate any plan for reducing the present scandalous evil is worthy of full discussion.

ECLAMPSIA.

In closing the discussion on eclampsia at the meeting of the British Medical Association a few weeks ago, the President of the Section, Dr. Herbert Spencer, remarked that the main points of the discussion were ignorance of the pathology, uncertainty of prognosis, and the recommendation ot gentleness in treatment. In other words, if the discussion at Leicester is to be regarded as a reflection of our present attitude toward eclampsia, it is one of almost complete ignorance as regards pathology, prognosis, and treatment. As is usual, however, in matters where there is little positive knowledge there is plentiful difference of opinion, and the views of pathology held by the members present at Leicester were even more various than the schemes of treatment. When one has said, however, that eclampsia is the result of the presence of a toxin in the body, and that such toxin may cause ecchymosis or patches of necrosis in the organs, one has said nearly everything that can be said with certainty of the pathology of the condition. There still remains a wide field for conjecture as to the source of the toxin, its nature, and the site of its activity in the body. As regards the latter point, some hold that it is freely circulating in the juices, while others believe that it is for the most part in close combination with fixed cells. On a decision of this question will depend in part the justification of one of the modes of treatment more often recommended than practised—venesection. As regards treatment, it is curious how long it has taken to decide for or against the induction of premature labour as the best means of preserving the woman's life. Some of the speakers at the Leicester meeting were strongly in favour of this procedure, but their arguments showed some lack of appreciation of the point at issue. For instance, much labour was devoted to justifying the sacrifice of the child which would probably die in any case, with the object of saving the mother. The question is, however, whether emptying the uterus has in fact the effect of saving the mother, and this point is far from established. When, therefore, a physician suggests that pregnancy should be terminated if a woman shows albuminuria with casts and deficiency of waste products, and boasts of having terminated five successive pregnancies in the same woman in order to spare her kidneys, it is necessary to emphasise the fact that it is yet unproved that termination of pregnancy is a benefit to the woman's health. The only figures immediately bearing on the point are those collated by Dr. Herman, and they show that the percentage of mortality after operative delivery was 25·5, while the mortality among those not subjected to operation was 20·8. While, therefore, the argument for immediate delivery is not complete when eclampsia is actually present, such operation can hardly be justifiable when eclampsia is only anticipated. As regards the sedative treatment of eclampsia, the general opinion at Leicester seemed to favour the morphia rather than the chloroform method, and those who distrusted the morphia method had for the most part misunderstood it and had probably failed by not administering sufficiently large doses. The whole subject of eclampsia remains one of the least known in the range of medicine, and the Leicester discussion is useful at least in emphasising the fact of our ignorance.

MEDICINE AS AN ART.

Reading, as we read each year, the October crop of introductory addresses at the medical schools, we cannot fail to notice that the lecturers find it increasingly difficult to say anything new. If these addresses are intended as a welcome to new students and a means of preparing them for their studies, perhaps originality is not much needed, as the same truths will serve year after year for different audiences. But it may safely be affirmed of three-quarters of the addresses that they dwell more or less exclusively on the scientific aspects of medical training, and it is on the points of view from which these aspects may be regarded that the lecturers ring the changes. Now, fundamentally important as science, properly so-called, and scientific methods are in the study and practice of medicine, it is not for scientific training, strictly speaking, that students present themselves at hospitals, nor, for it amounts to the same thing, is it for scientific accomplishments that the public employ doctors. Medical science exists for the purpose of forming and perfecting medical art, and is no more an arm in itself than are military manœuvres or naval evolutions. Each tends to produce efficiency in the emergencies of practice; but just as the soldier is employed to fight, so the doctor is employed to relieve and cure. There is, it seems to us, a lamentable lack of appreciation of this cardinal and elementary idea in the training provided by medical schools, and in the introductory addresses the reflection of this defect is mirrored. The theory that evidently prevails among medical teachers is that if a man be stewed in a scientific medium and stuffed with an accumulation of scientific facts, a resourceful, tactful, and accomplished practitioner will result. How far this is so, only general practitioners who employ qualified assistants and a number of patients who have fallen into the hands of the callow products of the schools can testify. It is often made the subject of comment that the most brilliant men at hospitals turn out unsuccessful practitioners, and that on the other hand students who underwent a severe series of reverses at the examining-table blossom into prosperous and portly doctors, whose door-bell is for ever clanging and whose coachman's life is a misery. Trite as these observations are, they suggest, not unreasonably, that there may be some cause at work to which they are ultimately referable, and making all allowance for opportunity, luck, and manner, we cannot help thinking that a most significant reason is to be found in the neglect—we might almost say, the contempt—with which the art of medicine is treated in hospital-schools. In the old days of apprenticeship, a youth who aimed at becoming a doctor, was compelled to learn his art at the hands of an experienced practitioner, before going to a hospital to acquire the science on which the art was founded, and though this process was an inversion of the logical one, the public were, as a rule, assured of obtaining the services of men who knew how to treat patients and how to relieve them. The treatment might be empirical, and often was, but it was conducted according to the circumstances and limitations of the patient, and was planned to bring him as much comfort and as speedy a cure as possible. Under the new *regime*, we venture to say that the bulk of students acquire their qualification to practise with but the dimmest knowledge of the art of medicine, and not only do they cause unnecessary suffering in acquiring their art, but they may ruin their reputations and careers in the process. The most crying anomaly in the students' training is the neglect of the art of gynæcology, most men leaving hospital with as little skill in gynæcological manipulations as they have in carpentry or mechanical engineering. Obstetrical teaching is almost as bad. Recently-qualified men who can put on forceps neatly, quickly, and with dexterity must be few indeed in number, and probably not one in ten has more knowledge of the other obstetrical operations than he has gleaned from books and common-sense. Minor surgery he picks up from the rough-and-ready practice of the casualty department, and if he is ever taught to do a dressing with the maximum of comfort to a patient and the minimum of disturbance to a wound, it is only because he has worked under an exceptionally skilful and painstaking house-surgeon. We make bold to say that the art of treating medical patients forms an item of negligible importance in the student's training. He hears lectures on the action of drugs and picks up wrinkles from his hospital pharmacopœia, but the studied attention to the symptomalogy of minor affections and the skill in meeting the necessities of individual cases which are of the essence of successful practice, he neither sees exhibited nor hears the value of. This is largely due to the fact that those from whom he draws his medical sustenance are not *artists* in the true sense of the word; the consulting physician being generally unable to teach the treatment and management of patients in their homes and family circumstances because he has never had to learn it for himself in the school of experience. The success of homœopathy, with its ridiculous theories and puerile materia medica, is due largely, if not entirely, to the fact that the homœopaths professedly devote themselves to symptoms, and it needs but little confidence in the superiority of scientific medicine to say that homœopathy would probably be dead in a couple of decades if "allopaths" cultivated their art to the degree that patients legitimately expect. It is a very fine thing to be able to differentiate albumoses and peptones in the urine, and a candidate may gain much kudos at the examination-table by being able to discuss the relative merits of the abdominal and vaginal route in hysterectomy; but the junior practitioner who has no ideas on either subject but can guide a patient safely and comfortably through an attack of influenza is the man whom patients will designate "clever," and from whom they will be likely to derive most benefit in the long run. But we gravely doubt if the art of managing influenza appears in the schedule of any course of lectures which the ordinary student is called upon to attend.

Notes on Current Topics.

Certificates for Watercress Sellers.

To those who watch the course of public health legislation, the reflection must constantly occur that people can no more be made healthy by Act of Parliament than they can be made sober by the same means. The moving force in both cases must be the creation of a public taste for better things as the result of a business demand or of moral education. For this reason one is inclined to favour those agencies that show preference for the clean and healthy without necessarily demanding a legal penalty from the unclean and unhealthy. The Southwark Borough Council being rightly persuaded of the danger to be apprehended from watercress grown in sewage-soaked marsh-lands, are about to request the London County Council to give certificates to those growers and sellers of watercress who can satisfy the Council that the farms from which their wares are derived are free from sewage-contamination. This seems to be a wise method of tackling a difficult question. If the public be accustomed to require a guarantee with their watercress, they will soon learn which sellers to patronise; and those who continue to deal in dirty and befouled cresses will be touched in the only place in which they probably can be touched—namely, in the pocket. A plan of this kind will cost but a fraction that austere preventive measure would run to, and is likely to prove at least as efficacious.

"Pure Herbal Pills."

It is to be hoped that the public may learn something of the methods by which they are gulled by such revelations as were recently made in the "Bile Beans" case, and by the perusal of the proceedings in Hanley County Court, a couple of weeks ago, when the proprietor of an article sold as "Dr. Astbury's Pure Herbal Pills" took proceedings against a rival who, it was alleged, imitated his label. It was admitted in evidence by the plaintiff that as far as he knew, there had never been any "Dr. Astbury"; the name had been bought with the stock-in-trade on taking over the business. Moreover, the "pure herbal pills" were shown to contain calomel—a drug not usually classified in the vegetable materia medica. It is hardly to be wondered at that His Honour, Judge Mulholland, was led to make some pretty severe remarks:—"Am I to be asked to exercise my jurisdiction in favour of a man who practically acknowledges that he has obtained money by false pretences from the public, and to protect the label which covers the false pretences on which he is obtaining the money? If you ask for equitable remedies you must come with clean hands. People know that every word on the label is untrue. The pills contain a large proportion of calomel, the very thing which people who fancy herbal medicines wish to avoid. It is also stated that they are worth their weight in gold. That may be puffery. Then it is said that they are made from a recipe of Dr. Astbury, which may be taken as holding out that he is a qualified medical practitioner—from his original recipe. All this is untrue, and it is all said to enable them to sell an entirely different article for the purpose of getting money. Now another man comes along, and he tells the same lie exactly, so that his lie is just as good as yours. He deceives the public just as readily, and then you say you want damages because he is preventing you having a monopoly of the lie. I nonsuit the plaintiff."

Carnegie College of Hygiene.

Mr. Andrew Carnegie is one of the few men in this world who suffer inconvenience from superfluous wealth, and it seems from his speeches and writings that it is almost as difficult to spend money well as it is to make it without exertion. Among Mr. Carnegie's many benefactions those to his native Dunfermline are least open to the criticism of those who find fault with his other endowments, and it is probable that his latest donation will produce as good interest in health and happiness to his own country as any that have preceded it. This gift, it will be remembered, was a capital sum producing in interest £25,000 a year, to be administered by trustees for the benefit of Dunfermline. Into all the details of the proposed expenditure—such as the improvement of Pittencrieff Park, the provision of a band, and the encouragement of art—we need not enter here, but we are specially interested in the College of Hygiene and Physical Training that was opened by Lord Linlithgow last week. This College is to provide training for a certain number of women-students in hygiene and physical exercises, and at the end of the course, which lasts two years, they are to be examined by the Royal Sanitary Institute and the Ling Association before receiving certificates. These women, it is hoped, will form a band of teachers through whose instrumentality the development and physique of the Scotch children will be rationally guided and improved, and already the College is arranging for courses of lectures to be given to elementary school teachers who reside in the adjoining towns and villages. Moreover, a medical officer has been appointed to supervise the health of the children now attending the Dunfermline elementary schools, with three qualified teachers under him to instruct the pupils in physical exercises. Public baths and a gymnasium, too, have been erected under the trust, and free tickets of entrance to them are provided for the children of the poor. Altogether it is difficult to conceive of a more beneficial form for private generosity to take.

Pneumonia and the New York Commission.

The first report of the New York Commission for the investigation of acute respiratory diseases can hardly be considered as adding much to our sum of knowledge on the subject. When, however, we remember that the report is signed by such men as Dr. W. H. Welch, of Baltimore, Dr. J. H. Musser, of Philadelphia, and Dr. Frank Billings, of Chicago, it will be conceded that anything stated therein has received a stamp of authority which may have been hitherto lacking. One of the main difficulties in the prevention of pneumonia has been the fact that the pneumococcus exists in large numbers in the mouths and respiratory passages of healthy people. This is emphasised by the report, which states on the authority of Dr. His that practically every individual exposed to such conditions as exist in New York during the winter months acts as the host of the true diplococcus pneumoniæ. Moreover, little difference was found in the virulence of the bacteria obtained from healthy people and from patients suffering from the disease. As regards the life of the organism outside the body, Dr. Wood states that the average duration is probably as much as two weeks, unless exposed to strong sunlight. When pneumoniæ sputum is dried and powdered, the organism, if exposed to the sunlight, dies in a few hours. It is therefore important in the treatment of the disease to bear in mind the bactericidal action of the rays of the sun.

Manifesto on Alcohol.

An original departure from municipal routine has been made by the Lambeth Borough Council. They have authorised their medical officer of health, Dr. Priestley, to issue placards, printed in double crown posters, warning the inhabitants of the borough of the dangers and evils of alcohol. These posters are to be displayed about the streets, and will it is hoped reduce the takings of the spirit vendors considerably. The substance of the placards is altogether admirable. It begins by pointing out that the evidence given before the Committee on Physical Degeneration showed that the abuse of alcohol was the most potent and deadly agent in the production of physical deterioration; that it is not only inimical to muscular vigour but favourable to tuberculosis and lunacy. Then, like a Scotch Minister's sermon, it divides itself into nine heads, each containing a pithy point about the enemy. All of these will meet with the approbation of the medical profession, for although nothing new is stated, the old ideas probably need plenty of driving into the heads of the denizens of Lambeth. The unfortunate part is that the placard is very long, and we rather doubt if the people whom it is designed to reach will take the trouble to study it. It might have been better to have secured the co-operation of the Salvation Army, who are past-masters at this sort of thing, or even of the advertising staff of the *Times* who are accustomed to making the blood run cold. But much as we sympathise with the objects of the Council, we wonder if the posters will do much good. Lord Beaconsfield, who probably knew men as well as anybody who ever lived, was of opinion that the issuing of manifestoes was of about as much, or as little, good as chalking texts on palings.

Inoculation Against Plague.

The ravages which plague has been making amongst the native population in India, especially in the Bombay Presidency during the last seven or eight years, have been appalling, and should have been sufficient to excite to action any but the most lethargic Government departments. The Indian authorities after a praiseworthy display of energy at the beginning of the epidemic, seem to have been overcome with the magnitude of the task before them, for the last few years have seen little action on their part beyond the publishing of weekly returns showing the number of cases and deaths. Now, however, there are signs of reviving interest, and one is glad to notice that in Bombay, which has long been the headquarters of the plague, direct preventive measures are again being tried. So far, these have been confined to inoculation on a small scale, but there is reason to hope that from this small beginning larger results may flow. The credit for these new measures belongs to Dr. Turner, medical officer of health for Bombay, who seems to be setting about his task with an enthusiasm which bodes well. He is endeavouring to popularise inoculation, and has written a short essay on the process and its advantages, which it is proposed to translate into the native languages—and to distribute widely. His efforts are being seconded by the Government and their officials, and in other towns in the Presidency like measures are being taken. Great care in the sterilisation of the inoculating syringes is being exhibited, the instrument being boiled in vaseline at 160°. Centigrade between each operation. It is to be hoped that no untoward accident like that which occurred in the Punjaub when inoculation on a large scale was tried will interfere with the popularity of the measure.

Professor Behring and Tuberculosis.

It would be folly in the present state of our information regarding Professor Behring's researches and conclusions to express any opinion either for or against his views. Anything that comes from Professor Behring is deserving of the utmost respect, for there is no man of science in Europe who conjoins more markedly the qualities of brilliancy in conception and soundness in result. Moreover, it is to Professor Behring that we owe one of the greatest boons in modern therapeutics—the anti-diphtheritic serum. On the other hand, speaking with all due reserve until further reports are at hand, Professor Behring's researches on the curability of tubercle seem to rest on one or two assumptions, which, though possibly well founded, have not as yet received universal assent. In the first place, it is assumed in opposition to Koch, that bovine and human tuberculosis are the same, or at any rate, that children are usually infected by the ingestion of milk. Further, Professor Behring's well-known view that tuberculosis in the adult is only a diffusion of the infection received through the alimentary tract in childhood, seems essential to the truth of his reasoning. This view has, so far, not received very wide support, as with its adoption, all our beliefs as to the infectivity of the disease from patient to patient would fall to the ground,

A Medical *Cause Célebre*.

There has been a *cause célebre* in medical circles in South Africa during the present year which illustrates the risks to which a physician is exposed in the discharge of his daily duty. The story as told in the *South African Medical Record* is, that "a young woman pregnant about four months endeavoured to bring about abortion by introducing a crochet needle into the vagina. She caused severe hæmorrhage, and for that consulted Dr. Nanji, who treated her for that hæmorrhage. There is not one tittle of evidence to prove that he did anything further. But, finding that she had not got rid of her incubus she con sulted another medical man requesting him to bring about abortion. She mentioned that she had been to Dr. Nanji, but of course did not, then at least, say anything about what she had done herself. When an examination by speculum revealed appearances of violence in the neighbourhood of the *os uteri*, the second medical man rashly jumped to the conclusion that they had been inflicted by his *confrere*. The result was the arrest of Dr. Nanji on a charge that broke down the moment it was properly investigated, and which never ought to have been made." There is no doubt that Dr. Nanji's conduct was correct in every particular, while that of his *confrere* was officious in the extreme. A medical man has no right to divulge private information gained in his professional capacity unless he is ordered to in the witness box, or unless it be necessary to prevent crime.

Anthrax and Wool-Sorters' Disease.

FROM time to time cases of anthrax are reported from various parts of the United Kingdom, but more especially from the great towns in which particular industries have to deal with foreign hides or wool. The cutaneous form is readily recognisable ; indeed in the London and Bradford anthrax districts workmen have learned the look of the disease for themselves. The importance of such knowledge is evident in face of the fact of the comparative curability of anthrax if the lesion be promptly excised. As to internal anthrax in the human subject, it seems likely that many of these attacks are never recognised. The patient is taken off to hospital, where he quickly dies, and his death is attributed to septic pneumonia or other acute pulmonary mischief. The only treatment of any use in internal anthrax is Sclavo's anti-anthrax serum. If injected freely in the early stages of the malady it may save life. It is also valuable in cutaneous anthrax. It is interesting to learn upon the authority of Dr. J. H. Bell, of Bradford, that external anthrax was not found amongst wool workers before 1880, although wool-sorters' disease had been recognised for more than thirty years. The probable explanation is that such cases occurred but were overlooked until it became known in the year mentioned that woolsorters' disease was an internal form of anthrax.

Poisonous Saccharin.

THE readiness with which certain pharmaceutical preparations, manufactured in the chemical laboratory and of identical composition with certain natural principles of herbs, are accepted and prescribed by the modern practitioner is a sign of the growing tendency to relegate drug-therapeutics to the pharmacist himself. Unfortunately, it not infrequently happens that the synthetic preparation falls far short of the natural substance in efficacy, as in the familiar instance of the artificially prepared salicylates. It is difficult to exclude impurities in the course of a complicated series of chemical reactions, and it is to these extraneous matters that the unpleasant effects of such synthetic compounds are supposed to be due. In the case of saccharin, which is more or less the sheet-anchor of the diabetic, there has been little or no complaint on the above-mentioned score. Besides its use as a sweetening agent in diabetes, saccharin is largely employed in tinned fruits, and also as an ingredient of mouth-washes. Although it is not a carbohydrate, it is, nevertheless a pretty universal substitute where cane sugar is prohibited. It will, perhaps, be a matter for some surprise to learn that Drs. S. A. Matthews and H. McGuigan, of Chicago have conducted an exhaustive research into the physiological action of saccharin upon the working of the various bodily processes. These observers have found that it produces a marked diminution of the oxidated power of the red corpuscles of the blood. In a series of experiments undertaken upon the digestive fluids, it was found that the addition of saccharin possessed a retarding influence upon salivary, peptic, and pancreatic digestion, the action of the various ferments especially being inhibited. Clinically, the long-continued use of saccharin was found to cause headache. In face of this report, saccharin can hardly be commended as a permanent substitute for sugar, either in health or sickness.

Register! Register!! Register!!!

THE Registrar of the General Medical Council has sent to the professional journals his annual letter of reminder of the necessity of notifying changes of address. At the best, the registration of qualified medical men, being optional, is a somewhat poor instrument, but it nevertheless fulfils some useful and important functions. In point of fact, many men whose names have been placed on the *Register* fail to notify changes of residence and their names are erased from the official roll. There is a great tendency on the part of medical men to confuse the official *Register* with Churchill's non-official *Medical Directory*. They think that if they see their name and other particulars correctly stated in the last-named excellent publication they may rest content. There are certain disqualifications connected with non-registration, which may or may not overtake the person whose name for any reason fails to appear in the official record. At any rate, it is an extremely simple matter for any registered medical practitioner to write to the branch registrar of the country in which he originally registered his medical qualification. The curiously lax and unbusinesslike character of the medical mind is testified most eloquently by the interminable array of names that appear in the *Directory* as "travelling" or "address uncommunicated."

A SERIOUS epidemic of diphtheria which broke out in Poplar, has been traced to a child named McCarthy, who died from diphtheria, a number of her school companions having kissed her after death.

The Army Nursing Home Scandal.

The Government appears to be bent on alienating the medical profession. The late war in South Africa has revealed the absolute inadequacy and feebleness of the Army medical system. That system is practically unaltered, in spite of a brave show of official inquiry and of resentful blustering denial. The need of reorganisation of the Army medical branch, however, is perhaps not really more vital to the interests of the nation generally than that of the Army itself. So far as the average citizen may judge, chaos, corruption and incompetence still darken the atmosphere at Whitehall. Scheme after scheme of Army reform has been launched before the eyes of a bewildered Parliament, but each has been abandoned in turn after money has been poured out upon it like water. The latest move of the War Office with regard to the new military hospital at Millbank clearly shows that the reign of common sense has not yet prevailed in that beclouded official region. The nursing home attached to the hospital is ill-planned, cramped and defective in many essential particulars. It appears that the War Office accepted the plans from an Engineer officer and carried them out in the teeth of sharp criticism from the Army Nursing Board. Her Majesty the Queen who has all along shown a warm interest in the new hospital, was so struck by the defects of the nursing home that she most kindly offered a sum of £2,000 towards its construction on an improved plan. That gracious offer the War Office, true to its red-tape traditions, declined point blank. If the War Office now declines private benefactions, why should it do otherwise in war-time? Why, for instance, was all the vast flood of private generosity accepted for the troops during the stress of the South African war. Why cannot the War Office that accepted chocolate boxes for the soldiers at the front from her late Majesty Queen Victoria accept £2,000 for the soldiers' nurses from her present Majesty Queen Alexandra? Perhaps Mr. Arnold-Forster, whose attempts at War Office reformation have been unwearying, will satisfy our curiosity upon these few points. He may be assured of one thing, namely, that the day is long past when the public will knowingly permit the bad housing of nurses.

Stage-Fright.

Solomon knew that "the fear of man bringeth a snare," but there is nothing to show that he was acquainted with the nervousness known as stage-fright, which, from a scientific point of view, has never been satisfactorily explained. Some of our prominent public speakers own to feeling nervous at times before mounting the platform, and with some the sensation never quite passes away. In the majority of cases, however, boldness succeeds diffidence, and the speaker speedily "warms up" to his subject. Other individuals, such as actors, pianists, and demonstrators, are unaccountably seized with an attack of morbid self-consciousness. A well-known doctor of music, in a recent lecture upon the subject, described stage-fright as being due to blushing of the brain. We must confess our inability to follow exactly the line of thought pursued by the learned professor in his excursion into the remote realms of cerebral pathology. As a matter of fact, a good deal of scientific and semi-scientific stuff about nerves and brain was hashed up in his lecture, and also appeared in his text-book, written for students taking up the course. It is only fair to mention, however, that this portion of his book was revised by a medical man. Nevertheless, we contend that it is most undesirable for a doctor in any other faculty than medicine to advance theories upon medical matters before a mixed audience, even if there be underlying them a substratum of truth. Any obstruction to the cerebral circulation was stated in the same lecture to induce attacks of stage-fright. If nothing worse than this results from the wearing of a tight collar, the individual so constricted has much to be thankful for. Meanwhile stage-fright is stage-fright. We doubt if scientific medicine at the present moment is able to go far beyond that definite statement.

The Danger of the Handshake.

It would seem that none of our social customs are safe from the iconoclastic hammer of the hygienist gone mad. Some time ago we were warned against the danger of reading our letters and our newspapers over the morning tea and toast, lest perchance the lurking microbe should be added to our meal. Now, a deeply rooted custom of civilisation is threatened—the social handshake. The leader of this new crusade is Dr. Valentine Valpasse, a physician attached to the Persian Embassy at Constantinople. He has discovered that every square centimetre of the skin of the hand shelters more than 80,000 microbes, while the same area on the arm or breast has not more than 25,000 inhabitants. The obvious suggestion would be to substitute an arm-grip or a rubbing of chests for the handshake as a social salute, but even this is too septic for Dr. Valpasse. There must be no contact. He has adopted, and he suggests to Europe to adopt, the Eastern mode of salutation of pointing to the heart, the lips, and the forehead. However, lest this reform appear too radical, it may be permissible to shake hands with the gloved hand, as it is stated King Edward does when he travels abroad. Perhaps, if Dr. Valpasse continues his investigations he will find that the average glove has quite an extensive bacterial flora, so that if the handshake is to be permitted at all, it might be wiser that we should be protected every time we meet a friend by a fresh pair of sterilised gloves.

Mr. Henry Morris, F.R.C.S., Senior Surgeon to the Middlesex Hospital, has made the munificent gift of £1,000 to form the nucleus of a Permanent Endowment Fund for the maintenance of the Medical School of the Middlesex Hospital.

PERSONAL.

Dr. R. Havelock Charles, Lieutenant-Colonel Indian Medical Service, has presented to the Royal College of Surgeons, England, a magnificent collection of skulls, representative of many of the Castes and Tribes of India and other parts of Asia. A special vote of thanks was unanimously passed to the donor, at the meeting of the Council on Thursday last.

The late Dr. William Woodward, of Hill View, St. John's, Worcester, for twenty-five years district medical officer, a member of an old Ledbury family, who died September 4th, aged seventy-five, left estate valued at £11,433 gross.

Mr. George Wyndham, M.P., attended a *conversazione* of the Chester Society of Natural Science and Literature last week and presented a portrait and a purse of two hundred guineas to Mr. Robert Newstead, formerly curator of the Grosvenor Museum, Chester, and now on the staff of the Liverpool Tropical School of Medicine.

Dr. R. S. Anderson, of Spennymoor, has been publicly presented with a silver tea and coffee service and other valuable gifts on the occasion of his leaving the town for New Zealand. Dr. Anderson has for many years taken a prominent public position and is leaving on account of bad health.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

SCOTLAND.

Charity Organisation.—The 31st annual meeting of the Glasgow Charity Organisation Society was held on the 9th inst, in the Merchants' Hall, under the chairmanship of the Duke of Montrose. The total applications for relief dealt with by the society during the year amounted to 10,094 cases. His Grace the Duke, in the course of his address, referred to the need of everyone, in their capacities as individuals, doing all they could to try to bring the question of the unemployed into a more hopeful position. He thought the first thing to be done was to separate the unemployable from the unemployed, and to deal with this question from these two standpoints. The unemployable might be sent to places, such as farm colonies, to learn to work, and the unemployed given help, according to their needs, from such a society as the above. He pointed out one paragraph in the report which referred to spasmodic giving, as being very important, and he said that every household ought to have a copy of it as charity given spasmodically was wasted. People ought to give to the like of this society, where the cases are carefully inquired into. The Lord Provost, in moving the second motion, "That this meeting commends the principles advocated by this Association as worthy of general adoption, and recommends the Association to the increased support of all classes of the community," referred also to indiscriminate giving, and said that a society such as this one did an immense amount of good in guiding charitable funds to the persons who really required assistance. A vote of thanks was afterwards given to the Duke of Montrose. Some of the speakers gave instances of people trying to obtain hospital and other charity by fraudulent means. If such a society as this could extend its sphere of work in order to prevent hospital abuse, much good would undoubtedly result. There should exist, between a well-equipped organisation like this society and the authorities of the various hospitals a close relationship whereby the many cases of gross abuse, which are so often heard of in connection with both the in and outdoor departments of our hospitals, might be prevented. The subject of this abuse of hospitals is constantly coming up, and no remedy has yet been found to prevent undeserving people from obtaining medical attendance, who are perfectly well able to pay professional fees.

Inebriates' Home, Greenock.—In last week's issue of The Medical Press and Circular, by a clerical mistake, it was stated that the cost for each individual was 1s. 11d. per week, whereas it should have been 11s. 11d. This sum will compare very favourably indeed with the cost of maintenance at other institutions of a similar kind; in fact, it is very considerably below that of the great majority.

Correspondence.

MONOTONY IN PRESCRIBING.

To the Editor of The Medical Press and Circular.

Sir,—I have received many communications in answer to my letter on this subject, several of my correspondents suggesting that it were better that I dealt less in generalities and gave a typical example. With your permission, Sir, I will accept the challenge and take as a specific instance one of the commonest of all complaints—chronic bronchitis and emphysema. This is a well recognised type of disease, it is essentially chronic and displays but little tendency towards self-cure. The unfortunate sufferers every winter wander from one medical adviser to another seeking in vain for even temporary alleviation. If they have sufficient money and leisure they leave the country and endeavour to find it in a warmer and more genial climate. But the majority are fettered by home ties and business responsibilities, and their only hope of relief is such as can be afforded by medicinal remedies. They may go to a dozen different doctors and will be given practically the same medicine. It will be ipecacuanha and squill with perhaps senega, or a mixture containing carbonate and chloride of ammonium. They naturally rebel against this monotony and take refuge in proprietary articles of unknown composition, often much to their own detriment. No one doubts the efficacy both of the carbonate and the chloride of ammonium as expectorants, but they are not the only members of the group. Iodide of potassium we all recognise as a most valuable drug in tertiary syphilis, in aneurism, and in many other complaints, but we are apt to forget that it possesses the power of removing and rendering less viscid the secretions of the bronchial tubes and air passages. Its mode of administration when directed to this end is a matter of some importance. Sufferers from chronic bronchitis cough most in the early morning either on awakening or during the time of dressing, and they with much labour and distress go through their "spittoon exercise." If the mucus is tenacious and viscid it is difficult to dislodge, and the muscular effort involved tends to dilate the circumferential air vesicles and throws an additional strain on the overburdened heart. This distressing condition is readily relieved by the simple expedient of giving fifteen grains of iodide of potassium at bed-time. It is not necessary to prescribe it in the form of a mixture, for three five-grain tablets dissolve readily in half a tumbler of cold water and the taste is by no means unpleasant. The following morning it will be found that the bronchial secretion is less, that it is limpid in character and comes up quite easily, without coughing and without effort. This may seem but a small matter but it makes a material difference in the comfort of the patient and also in the duration of life of an elderly man. If by chance the sufferer should have an old syphilitic taint the indications for the administration of this particular remedy are still more pronounced. When the patient has a dilated heart and there is a fear that the potassium base may exert a depressing influence, especially when taken at bed-time nothing can be simpler than to substitute the corresponding sodium or ammonium salt. The iodides, even in very small doses, may induce iodism in susceptible people, but a single dose well diluted at bed-time rarely produces either coryza or a rash on the skin.

Senega is an efficient stimulating expectorant, diuretic, and diaphoretic, but it is a nauseous remedy and tincture of quillaia in drachm doses made from soap-bark, which also contains saponin, is equally efficacious and much pleasanter to take. If a really powerful expectorant is required nothing can be better than small doses, say a tenth of a grain of hydrochlorate of apomorphine (or for the matter of that of apocodiene) given by mouth. When administered hypodermically it is an emetic, but when given as suggested it no longer acts in this way but promotes expectoration. Although a derivative of morphine it has an entirely different pharmacological action and the salts of both alkaloids may be administered together, a combination which in many cases is a very happy one.

For occasional use pure terebene is a good remedy and may be given in ten-minim doses on a lump of sugar or on a crumb of bread, or it may be inhaled from the hands or from a pocket-handkerchief. The directions commonly given that it should be inhaled from a jug of hot water are quite unnecessary, for it is freely volatile at ordinary atmospheric temperatures. A good combination for an inhalation is a mixture of pure terebene, pinol, and a few drops of lemon eucalyptus.

Another valuable remedy in chronic bronchitis is tar, not coal tar, but wood tar, the pix liquida of the Pharmacopœia. It is an inexpensive remedy, and in two-grain doses may be made into pills with lycopodium. The syrup of tar of the United States Pharmacopœia although somewhat weak is a pleasant preparation and quite apart from its therapeutical properties is valuable as a flavouring agent. A mixture of two parts of syrupus picis and one of syrupus pruni virginianæ makes a good linctus. For dispensary practice tar water made by stirring together equal parts of tar and water until the tar finally sinks to the bottom costs practically nothing. In some parts of the United States tar beer made much in the same way has a large sale. For those who are more fastidious capsules of tar or the dragées de Christiania au goudron de Norvege are readily obtained. A much advertised preparation of tar recommended for coughs and colds is simply a solution of tar in old Jamaica rum.

Belonging to the same category and a most valuable remedy in this condition is benzol—a mixture of homologous hydrocarbons obtained from light coal tar oil, which is conveniently administered in the form of "drops" containing pure benzol one and a half drachms, oil of peppermint half a drachm and olive oil to two ounces, the dose being twenty drops on sugar.

Another good remedy is chekan, the leaves of myrtus or engenia chekan, belonging to the myrtaceæ. It is prescribed as a one in one liquid extract in drachm doses in water. As usually dispensed, it is a nauseous and unsightly preparation, but when freed from its chlorophyll it is pungent, aromatic and agreeable to the taste. It is comparatively little used, but yields excellent results.

Cubebs is another good remedy, and is just as reliable in bronchial catarrh as in catarrh of the urethra. I usually give a drachm of the tincture in a cup of linseed tea, flavoured with lemon, directed to be sipped slowly immediately after breakfast. It may produce a rash, but that is a matter of little importance. Cubebs cigarettes, although pungent, are useful, and a good combination for inhalation is a mixture of oil of cubebs, oil of sandalwood, and oil of lemon. An allied remedy to cubebs is gurjun oil, an oleo-pesin from dipterocarpus turbinatus, which is also useful in relieving bronchitis and incidentally in producing a rash. When asthmatic symptoms prevail the liquid extract of grindelia robusta will be found useful, although different samples vary much in activity. Painting the chest and back with equal parts of liquor iodi fortis and a tincture iodi is just as useful as it is in phthisis and should never be omitted. Another good local application is oleum succini or amber oil, a remedy used in many parts of the country for whooping-cough.

From these scattered notes it will readily be seen that there need be no monotony in prescribing for chronic bronchitis. These remedies should not be prescribed indiscriminately, for each of them has its own particular sphere of action and success attends those who are familiar with their usefulness and limitations.

With regard to the kindly suggestion of "One of the Old School," that I should indicate the best training for a student in materia medica, I am afraid I have little to suggest with the exception that I would abolish lectures on materia medica and devote more time to the writing of prescriptions. I would give the man three months in a pharmacological laboratory and make him practically acquainted with the action of aconitine, digitalin, atropine and other alkaloids on the frog's heart and with the effects of strychnine and its congeners on the nervous system, observations which could be readily made without cruelty to the animal or infringement of the Vivisection Act. I would give him six months' dispensing under the supervision of a skilled pharmacist or of a doctor of the old school who dispenses his own medicines.

I am, Sir, yours truly,
William Murrell.

Welbeck Street, W., Ocotber 13th, 1905.

To the Editor of The Medical Press and Circular.

Sir,—It is quite true that we are all apt to fall into ruts in prescribing, and it is not less true that we are, or ought to be, grateful for such useful "tips" as Dr. Murrell gives us in his letter to you. Routine procedures doubtless argue a want of wide knowledge of pharmacology and a want of skill in prescribing. On the other hand, they indicate a desire to keep to what has been tried and not found wanting, rather than to sally into fields where there are a good many more failures than successes. Most of us general practitioners find that with two preparations of strychnine, two of opium, an alkali, a couple of bitter infusions, the bromides, mercury, and a cough mixture or two we can successfully treat three-quarters of the cases that we are called upon to attend. After many years' experience we become so familiar with the action of these preparations, and so certain of our ability to give relief, that we are loth to tempt Providence by embarking on the hundred and one novelties and strange, vaunted drugs that catch our eye in every medical journal we read. Speaking for myself, I can say that on several occasions when I have adventured into the wonderlands of new pharmacopœias and advertising columns I have had reason to regret my boldness, for one either has a message from the chemist to say that there is a precipitate at the bottom of the bottle or the patient returns with certain fresh symptoms which one does not know whether to ascribe to a fresh development of his complaint or to some action of the medicine with which one is unfamiliar. I confess I fail to see any advantage in prescribing fancy drugs till one has tried the old ones and failed. In the latter event one proceeds to run through the gamut of everything recommended; but it is significant of one's wisdom in generally cleaving to the old friends that one seldom finds anything sufficiently useful and striking to make one adopt it as a routine drug. Occasionally there are exceptions. I may instance my happy introduction to urotropine as a case in point. Tried, in the first place, after alkalies, hyoscyamus, belladonna, and benzoates had failed, urotropine so firmly impressed itself on one's mind by its almost magic action that I now give it as a routine practice in cystitis, and do not try anything else till it has proved inefficient. Chloralamide and paraldehyde are two examples of similar addenda to my own official pharmacopœia. But we general practitioners who have not troops of out-patients on whom to essay the latest products of Teutonic laboratories or drugs unearthed from other official or unofficial sources, but have patients who want to be cured *tuto, cito, ac jucunde*, prefer not unnaturally to "stick to the whiskey we're used to." To say this does not mean that we are ungrateful for good suggestions for second strings to our bows, and I, for one, have marked tincture of iquatia and turpethum for early insertion, with many thanks to Dr. Murrell for the suggestions.

I am, Sir yours truly,
FAMILY PRACTITIONER.

Oct. 15th, 1905.

THE DEATH OF SIR HENRY IRVING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The sudden death of the greatest actor of the age has thrilled the heart of the community with the sense of irreparable loss. His monument will long endure in the memories of men. It would be hard to better the epitaph of Hall Caine :—" He was tender to women, faithful to friends, lovable to his companions, and generous to all who needed aid." But my object in writing is to draw attention to the fact that death in this case was almost certainly due to an over-taxed heart. Sir Henry Irving had been suffering from a "slight cold" and a week or ten days before the end showed marked signs of feebleness at a public reception. My reading of this event is that the "slight cold" was unrecognised influenza, and that the feebleness was due to the weakened heart-muscle that so constantly accompanies that malady. Then comes strenuous work on the stage for a whole week, at the end of which the overtaxed heart gives way. All medical men in busy practice must have seen many cases of this kind, where absolute safety may be found in rest and quiet. Even apart from influenza the fatal syncope in this case was almost certainly the result of violent and prolonged physical exertion at a time when the circulatory system was for some reason or other below par. It is to be hoped that medical men generally will not fail to point the moral of this calamity. In that way, a great national loss may become to some extent a national gain, that is, if the people be thereby brought to recognise the folly of attempting to "shake oft" slight ailments, and of trusting to the doctoring of chemists and of amateurs instead of seeking the most skilful and responsible medical advice at command.

I am, Sir, yours truly,
DAVID WALSH, M.D.

London, W. Oct. 17th, 1905.

Literature.

TRANSACTIONS OF THE ROYAL MEDICO-CHIRURGICAL SOCIETY. (*a*.)

THE outline of the history of the Royal Medical and Chirurgical Society that the authors have compiled from the minute-books and transactions of the Society make the most interesting history of the progress of medicine during the century that we are acquainted with. Every page of the book tells how carefully the records have been examined and sifted, and not infrequently the authors draw attention to papers read before the Society, which although not valued sufficiently at the time to be included in the published transactions, have become highly prized as intelligent interpretations of disease that after years confirmed. The members of the Society include almost all the names of those who promoted medical and surgical progress in Great Britain, and to all who find pleasure in knowing how much scientific medicine has been advanced by English practitioners the work will be a constant source of pleasure. It would be impossible to enumerate a tithe of the subjects dealt with, but we may just refer to the discontinuance of bleeding, the introduction of anæsthetics, ovariotomy, laparotomy, cerebral surgery, antiseptics, aseptics, the treatment of tuberculosis, and of gastric ulcer. It is a pleasure to review such a book and we heartily congratulate the authors on its production.

TRANSACTIONS OF THE ROYAL ACADEMY OF MEDICINE IN IRELAND. (*a*)

THIS volume consists of 400 pages and is composed of numerous excellent papers, many of which are illustrated by plates and drawings. Judging by this volume of Transactions the society must be in a flourishing condition, and should be of great benefit to the members of the medical profession in Dublin. Among so many papers on varied subjects, we can only mention a few which have appeared to us of special interest.

In the first section, that of Medicine, is a paper which should appeal not only to physicians, but also to surgeons. It records the history of a case of innominate aneurysm which had been shown to the Academy in 1898 ; the patient who was then sixty-five years of age presented the physical signs of an innominate aneurysm in June 1897. He was treated by rest in bed for two months, sparing diet and the administration of iodide of potassium, at the close of the year 1897 he was free from all symptoms, and an examination eighteen months after the onset, except for a slight prominence and diminished resonance where the tumour had presented, there was absolutely no physical sign of an aneurysm to be found. On April 27th, 1904, the patient was at a dinner party apparently in perfect health, on the 30th he remained indoors as he felt out of sorts, that night he suddenly sat up in bed, blood began to pour from his mouth and in a few moments he was dead. At the post-mortem examination an old aneurysm of the innominate was found partially filled with coagula and with walls about one inch thick ; a second aneurysm of the arch of the aorta was found with a cavity the size of a new-born child's head, this had burst into the œsophagus and caused death. The interest of the case lies not only in the cure of the innominate aneurysm, but also in the sudden death from another aneurysm, which, in spite of its great size, had caused no symptoms.

Another paper entitled "The Bacillus Coli Communis as a Cause of Septicæmia," is founded on a fatal case of Septicæmia in which the colon bacillus was the only organism obtained from cultures made of the blood and various organs ; the history of the case is accompanied by a very full and critical account of the literature of the subject.

The part dealing with the Surgical Section is nearly as large as any two of the other sections. In it a paper entitled "Inefficient Operations for Gastric Ulcer," gives histories of four cases in which the ulcer was infolded, the ulcer was excised, a gastrogastrostomy was performed for hour-glass contraction, and a gastro-duodenostomy (not Finney's) was performed for pyloric obstruction due to cicatricial contraction. All these operations were perfectly successful at the time, but in each case, after a variable period the symptoms returned, and finally a gastro-enterostomy was done, which gave permanent relief. There are two other cases related in which gastro-enterostomy was followed by persistent vomiting, and were submitted to further operation. In the first case, a lateral anastomosis was made between the afferent and efferent loops, this caused no improvement, and the patient died ; in the other case the afferent loop was divided, the distal end closed and the proximal implanted into the efferent loop, this operation was followed by complete relief of the vomiting. The explanation of these failures, suggested by the author is, that the pyloric sphincter continues to act and therefore prevents complete rest of the stomach, at the same time that it leads to the retention of irritating substances. He concludes, therefore, that the proper surgical procedure for the relief of symptoms dependent on gastric ulcer or its sequelæ is to be found in a properly performed gastro-enterostomy, or possibly in cases of ulceration at some distance from the pylorus the modern operation of

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(*a*) "The Royal Medical and Chirurgical Society of London Centenary, 1805-1905." Written at the request of the President and Council, by Norman Moore, M.D., F.R.C.P., Honorary Librarian, and Stephen Paget, F.R.C.S., Honorary Secretary. The Aberdeen University Press, Limited. 1905.

(*a*) "Transactions of the Royal Academy of Medicine in Ireland. Vol. XXIII. Dublin : John Falconer. 1905.

Finney may be found satisfactory. Our own idea is that very few, if any, cases are suitable for Finney's operation, certainly not those cases where there are contractions or adhesions anywhere near the pylorus, as they are liable to recur, as in the fourth case reported, and not in those cases where the stomach is greatly dilated and in an atonic condition, as no matter how large the opening is made it is not in the most dependent position and therefore drainage, the most important point in these cases, is not efficiently provided for.

Following this is a paper on "New Methods for the Performance of Herniotomy for Inguinal and Femoral Herniæ." The operation in each case resembles that of Bassini, except that the stitching is done from the inside instead of the outside, a vertical incision being first made through the rectus muscle and transversalis fascia, the peritoneum is then stripped back from the anterior abdominal wall and the stitches are passed by a special handled-needle. The advantages claimed for this method are that it does not entail any division of muscle or the sacrifice of any nerve or blood-vessel of importance. The author states that the operation is specially suited for large herniæ of old standing; it may be suitable for these, but for ordinary cases it appears to be rather a heroic measure and unnecessarily difficult, considering the excellent results obtained by the ordinary Bassini method. There is a long paper on "Conservative Perineal Prostatectomy, in which there is a very full description of Dr. Young's method of performing the operation by the perineal route with the aid of his own prostatic tractor. It is well illustrated by several drawings and diagrams, and there is an account of two cases treated by this method.

Another paper of special interest is one "On Operation for Closure of Cleft Palate in Infants." In this the author describes the operation of Brophy, of Chicago, he records three cases on which he has performed this operation with satisfactory results.

HERSCHELL ON INDIGESTION. (a)

The third edition of Dr. Herschell's book on indigestion, provides one of the best guides to the study of this condition in the English language, and may, we think, be fairly regarded as a standard text-book. Entirely re-written, in its present form it embodies such of the most recent methods of diagnosis and treatment as can be readily utilised in daily practice. Commencing with an account of the physiology of digestion which, whilst by no means exhaustive, yet fulfils its purpose of reminding the reader to grasp the practical points, the author reviews the factors which may interfere with the normal digestive process, and discusses the production of symptoms. In the succeeding chapters the diagnosis and treatment of the functional derangements of digestion are exhaustively discussed, an adequate position being assigned to modern physical methods of treatment. The keynote of the whole book is insistence upon the fact that a diagnosis of indigestion is rarely more justifiable than one of dyspnœa would be, it being the duty of the practitioner not to rest satisfied until he has ascertained the exact pathological conditions which underlie the symptom-complex. A chapter upon modern intragastric methods of diagnosis will well repay perusal. Whilst not insisting upon the use of the stomach tube in all cases, the author lays down distinct and definite rules when it must be used and when a diagnosis is practicable and justifiable without it. The diagnostic methods themselves which are given are carefully selected and simplified in such a manner as to be practicable for a medical man without special laboratory experience. The value of the book has been greatly enhanced by the addition of an appendix dealing in a practical and scientific manner with the preparation by cooking of the special articles of diet which have to be constantly prescribed in the treatment of dyspeptic conditions. Taking it as a whole, we can conceive of no more valuable book to place in the hands of a medical man commencing practice, and it is not too much to say that having once perused it he would not afterwards willingly be without it.

DE SANTI ON MALIGNANT DISEASE OF THE LARYNX. (a)

This monograph is a concise, well-arranged and serviceable description of our still scanty knowledge regarding carcinomatous and sarcomatous neoplasms involving the larynx. The author rightly devotes much space to a description of the lymphatics of the larynx, and discusses the application of anatomical facts to the growth and extension of malignant tumours in the larynx. The most useful portion of the volume is that which summarises the methods and results of operative interference. The work is one which admirably meets the requirements of the busy practitioner desirous of ascertaining readily the present situation regarding the pathology and management of malignant disease of the larynx.

Laboratory Notes.

PLASMON CUSTARD POWDER.

The International Plasmon, Ltd., are very favourably known to the profession through their celebrated preparation, "Plasmon," which is so extensively and satisfactorily used as a means of enriching a dietary with proteid. We have examined a new departure of the firm—Plasmon Custard Powder—with very satisfactory results. Ordinary custard powders usually contain little else than starch and colouring matter. A few contain albumenoids to the extent of 5 or 6 per cent., but many do not contain more than traces; hence the addition of a considerable quantity of Plasmon is a distinct improvement which considerably enhances the dietetic value of the preparation. We have obtained the following figures as the result of our analysis —

Proteids (containing 4·79 per cent. of nitrogen), 30·32 per cent;
Water, 14·38 per cent;
Mineral matter, 3·40 per cent.

The preparation contains no poisonous metals, and is the only custard powder with which we are acquainted which is in any way entitled to claim to be a substitute for eggs in the preparation of custard.

New Preparations.

A FOOD FOR ANÆMICS.

The value of a pure Olive Oil as an addition to the dietary is too well known among practitioners to need further recommendation. Therapeutics have established that fatty oils are an important constituent in foods for anæmics. Both good oil and nutritious food may be found in the newly introduced "Skipper Sardines." We are informed that they are the finest selected autumn caught fish that are taken in great quantities from the fjords of Norway. The catch is immediately taken to the curing house, where is imparted the delightful flavour that makes the "Skipper Sardine" distinctive. Next to the packing house, where scores of busy girls in neatest uniform thoroughly clean and dress the fish, remove the heads and fins, and prepare them for the tins, this part of the work being carried out on marble-topped tables. Of the quality of the olive oil used in curing and packing "Skipper" Sardines, Messrs. Brady and Martin, analysts, of Newcastle-on-Tyne, certify: "We have examined the oil used in preserving the fish separately, and found it to be pure olive oil of excellent quality. We have found the sardines to contain the full proportion of the constituents natural to the fish. We have formed a favourable opinion of the quality of this brand of sardines as an agreeable and valuable food, especially in cases where cod liver oil cannot be easily taken or digested."

(a) "Indigestion: the Diagnosis and Treatment of the Functional Derangements of the Stomach." By George Herschell, M.D. London: H. J. Glaisher. 1905.

(a) "Malignant Disease of the Larynx." By Philip R. W. De Santi, F.R.C.S., Surgeon to the Throat, Nose, and Ear Departments, Westminster Hospital. Pp. 107, crown 8vo. London: Bailliere, Tindall and Cox. Price 4s.

ENDRENINE FOR LOCAL ANÆSTHESIA.

For some time past cocaine has held the field in the production of local anæsthesia. It needs little argument to show that the anæsthetic influence is likely to pass off with a rapidity directly proportionate to the time taken up in absorption of the drug into the general circulation. Hence, anything that delays local absorption will extend the duration of the cocaine anæsthesia. Such a retarding agent is found in adrenalin which acts probably by its inhibitory local action upon vascular activity. The outcome of these considerations has been the introduction of a compound named "Endrenine," by Messrs. Parke, Davis and Co. A combination of cocaine with adrenalin is supplied in concentrated form, put up in convenient-sized glass tubes. The surgeon wishing to produce local anæsthesia for any small operation has m rely to break off the tapering end of one of the Endrenine tubes and inject its contents under the skin by means of a hypodermic syringe. For tooth extraction and minor surgery it would be difficult to imagine a more handy and practical addition to the operators' armamentarium.

Obituary.

ALEXANDER HAY, M.D.GLASG., J.P., OF MARYHILL.

The death occurred, on the 8th instant, at The Grange, Maryhill, of Dr. Alexander Hay. Deceased had been in indifferent health for some time. Dr. Hay, who retired about fifteen months ago from active practice, was 64 years of age, had been in practice in Maryhill for over forty years, and had held the position of casualty surgeon since the annexation of the burgh to Glasgow. He was also certifying factory surgeon and parochial medical officer for Maryhill. He was born at Kirkintilloch, and educated at Glasgow High School and University. He was an M.D. and Fellow of the Faculty of Physicians and Surgeons (Glasgow), and was also a Justice of the Peace. Dr. Hay is survived by a widow and two sons and two daughters.

DR. J. CALDWELL, OF SALTCOATS.

The death occurred recently of Dr. J. Caldwell, who had reached the advanced age of 75, at Saltcoats, where he had been living in retirement. Having qualified in 1855, he offered his services as surgeon for the Crimea, and served in that position till the finish of the war. He then started practice at Morningside, and afterwards went to Dreghorn, where he made a large number of friends. In 1868, he obtained the post of medical officer of the Shotts Iron Company, and he fulfilled the duties of this position for 35 years, till his retiral. On that occasion he received an illuminated address with 450 signatures and a gold albert. He was much esteemed by all classes of the community.

THOS. H. PASSMORE, M..R.C.S.,L.S.A.,Eng.

The death of this gentleman occurred last week at his residence, Warleigh Road, Brighton. Deceased was for several years Government Medical Officer for St. John, West Indies, and subsequently Medical Officer of Health in South London for the district of Dulwich, from which post he retired some time since. Mr. Passmore obtained his membership of the Royal College of Surgeons, England, and the L.S.A. as far back as 1861.

Royal College of Physicians in Ireland.

The annual stated meeting of the Royal College of Physicians of Ireland will be held on St. Luke's Day, October 18th. The annual dinner which is usually held on the same evening has been postponed until Saturday, the 21st inst.

Medical News.

Royal College of Surgeons of England.

A quarterly meeting of the Council was held on Thursday last, Ocotber 12th, Mr. John Tweedy President, in the Chair. The death of Mr. Christopher Heath, past president of the college, was reported and a resolution of condolence with the members of his family was adopted. Diplomas of membership were issued to Charles David Mathias and Ismay Donald Stubbs, and a Licence to practise dental surgery was granted to Francis Joseph Goodman. The Museum Committee reported that Lt.-Col. R. Havelock Charles, I.M.S., M.D., had presented to the College a large collection of skulls and other specimens, representative of many of the Castes and Tribes of India and other parts of Asia. It was unanimously resolved that the best thanks of the Council be given to Lt.-Col. Havelock Charles for presenting to the College his collection which the Council regard as a most valuable addition to the Museum not only on account of the great number of the specimens, but also on account of the authentic particulars attached to them. The loan of Museum specimens to the Army Medical Department for examination purposes was renewed for another year. The report to be presented to the Fellows and members at the annual meeting on Thursday, November 16th, next was approved and adopted. Mr. Arthur S. Underwood was re-elected a member of the Board of Examiners in Dental Surgery. A report was received from the visitors appointed by the Royal Colleges of Physicians and Surgeons to report on the various courses of study and examinations in Tropical Medicine at institutions in the United Kingdom. This report was received and entered on the minutes, and it was determined to invite the Royal College of Physicians to hold a conference in reference to the questions raised in the report.

Society for the Relief of Widows and Orphans of Medical Men.

A quarterly Court of the Directors of this society was held on Wednesday last, October 11th. Mr. Willett senior vice-president present, in the chair. The death of Mr. Christopher Heath, late President of the Society, was reported. Mr. Heath was elected a member in 1874, director in 1879, vice-president in 1892, and president in 1900. During his term of office as president, Dr. Heath was only absent on two occasions from the meetings of the society. The following resolution was moved from the chair, and a copy sent to Mrs. Heath, together with the assurance of the sincere sympathy of the Court of Directors with the family of Mr. Heath in their bereavement—"The Court of Directors of the Society for Relief of Widows and Orphans of Medical Men hereby records its great regret at the death of Mr. Christopher Heath, who held the office of President since the year 1900, and who had for many years taken great interest in the society's welfare." Three other deaths among members were also reported. The death of a widow was announced, who had received a total sum of £1,295 in grants, the amount of subscriptions paid by her husband having been £21. Two new members were elected. The sum of £603 was voted as a Christmas present to be distributed among the annuitants of the Charity. It was also decided that in future the Quarterly Courts be held at 5.30 instead of at 8.30.

Opening of the Irish Medical Schools.

The Meath Hospital held its opening meeting of the forthcoming session on October 9th, when, in the presence of a large gathering presided over by the Earl of Meath, Sir John Moore delivered an inaugural address, which we reproduce elsewhere. After the address, Sir William Smyly was moved to the second chair, and a vote of thanks to Lord Meath for presiding was moved by Dr. Kidd, seconded by Dr. Sibthorpe, and passed by acclamation. In acknowledging the compliment, Lord Meath referred to the fact that the foundation stone of the hospital had been laid by Lord Brabazon, an ancestor of his own. His Lordship then proceeded to give excellent advice to young qualified men by telling them that if he was in their place his first wish would be to travel and see the other great hospitals of the world, and he added that were he a millionaire he would like to place it in their power to do so. Lord Meath's suggestion is an admirable one. If medical schools are to become and to remain great, their teachers must have seen other similar institutions in other lands, and the same remark applies to individual medical men.

The opening meeting of the forthcoming session of St. Vincent's Hospital was held on the following day, when Dr. Cox delivered an interesting address. The chair was occupied by Sir William Smyly. In the course of his address Dr. Cox referred to many notable persons who had been connected with the Hospital since its foundation, by Mrs. Mary Aitkenhead, some seventy years ago. Enumerating amongst others, O'Ferrall, and Bellingham, O'Connell, Gerald Griffin, D'Alton Williams, Cryan, Quinlan, and Mapother. A vote of thanks was proposed by Mr. Bodkin, K.C., and was seconded by Sir John Moore. Mr. Chance was then moved to the second chair, and a vote of thanks to Sir William Smyly for presiding was proposed by Mr. McArdle, and seconded by Mr. Tobin. The meeting then terminated.

Royal Academy of Medicine in Ireland.

The annual general meeting of the Academy was held on Friday last. The following appointments were made:—General Secretary: James Craig. Secretary for Foreign Correspondence: Sir J. W. Moore.

Medical Section.—President: Sir William Smyly. Council: H. T. Bewley, M. J. Dempsey, H. C. Drury, T. P. Kirkpatrick, G. Peacocke, F. C. Purser, R. Travers Smith, W. Langford Symes, W. J. Thompson, W. A. Winter.

Surgical Section.—President: Arthur Chance. Council: R. C. B. Maunsell, Sir Lambert Ormsby, E. H. Taylor, W. Taylor, W. I. de C. Wheeler.

Obstetrical Section.—President: R. D. Purefoy. Council: Paul Carton, J. H. Glenn, R. P. Farnan, A. J. Horne, H. Jellett, F. W. Kidd, A. J. Smith, T. H. Wilson.

Pathological Section.—President: J. F. O'Carroll. Council: J. B. Coleman, H. C. Earl, E. J. McWeeney, H. C. Mooney, T. G. Moorhead, A. C. O'Sullivan, J. A. Scott, John B. Story, A. H. White, J. T. Wigham.

Section of Anatomy and Physiology.—President: E. H. Taylor. Council: A. F. Dixon, P. J. Fagan, A. Fraser, H. M. Johnston, J. Alfred Scott.

Section of State Medicine.—President: F. C. Martley. Council: T. P. C. Kirkpatrick, Sir John Moore, A. Roche, W. A. Winter.

St. Bartholomew's Hospital, London.

The following entrance Scholarships have been awarded:—*Senior Entrance Scholarships in Science*—Value £75 each. 1. J. L. Joyce; 2. R. Crawford. *Junior Entrance Scholarships in Science*—Value, £150: 1. K. Bremer; 2. W. C. Dale, Esq. *Preliminary Scientific Exhibition*—Value, £50. R. Pearse. *Jeaffreson Exhibition in General Education*—Value £20. C. A. Prada. *Shuter Scholarship*—Value £50: R. B. Seymour Sewell.

Sheffield University—The New Medical Buildings.

The new medical buildings of the Sheffield University have now been opened, and are in full working order. The general arrangements and the very complete equipment of the various laboratories have produced a most favourable impression, and there is a strong feeling that this, the youngest of the English Universities, need not, as regards its medical side, fear comparison with any of its seniors. We hope it will attain the success that so spirited an enterprise deserves.

King Edward the Seventh's Coronation National Fund for Nurses in Ireland.

A meeting of the Council of the above society was held at 86, Lower Lesson Street, on Wednesday, the 11th inst. The Right Hon. the Earl of Meath, P.C., H.M.L., President of the Council of Management presided. The Honorary Treasurer's Report for the quarter ending Ocotber 1st, was received; and a direction given for the investment, to add to capital, of £100, a portion of the balance in current account. Applications from eight nurses for membership were considered, and six of these were accepted. Nurses requiring information regarding the Society are requested to apply to the Secretary, 86, Lower Leeson Street, Dublin.

The Cholera.

The *London Gazette* states that the Board of Trade have received a message from Stockholm intimating that the Swedish Government have declared the Prussia provinces of East Prussia and Posen and the Government district of Stettin to be infected by cholera, and a message from Christiania saying that the Norwegian authorities have added Posen, East Prussia, and Poland to the list of places declared to be infected by cholera. A message from Constantinople says, "Free pratique granted to arrivals from Aden, Port Said, and Damietta; twenty-four hours' observation with disinfection and rat destruction imposed on arrivals from Alexandria."

Pass Lists.

University of Glasgow.

At the recent professional examinations for the degrees of M.B., Ch.B., the following candidates passed with distinction in the subjects indicated:—

First Examination.—In Botany and Zoology: William Howat, M.A. In Botany and Physics: David Thomas Crichton Frew, William M'Adam, M.A. In Botany and Chemistry: James Lachlan Ure. In Botany: Alexander John Archibald, James Thomson Dick, David Campbell Suthie, Douglas Young. In Zoology: James Kirkwood Dunlop, William Howie, Agnes Mary M'Michael, John Park Mathie, Henry Joseph Windsor. In Physics: James Buchanan, John Gibson, Edward George Glover, Robert Dunlop Goldie, Kenneth Charles Gordon Gray, Allan Byars Hamilton, William Thomson Lindsay, Robert Buchanan, Forbes M'Kail, George Macleod, Mary Cochran Mitchell, John M'Naught Scott, M.A., David Yellowlees.

Second Examination.—In Anatomy, Physiology, and Materia Medica and Therapeutics: David Alexander Thomson, M.A. In Anatomy and Physiology: Alex. Tulloh Inglis Macdonald. In Physiology: Matthew Ignatius Thornton Cassidy, Arthur Drummond Downes, M.A., John Clark Middleton, M.A., Thomas Miller, Ralph Montgomery Fullarton Picken. In Materia Medica and Therapeutics: James Hogg, Martin, John Wilson Miller, Campbell Kay Stevenson, Hugh Johnstone Thomson, Matthew Young.

Third Examination.—In Pathology: James Dunlop Kidd. In Medical Jurisprudence and Public Health: Peter Mitchell, M.A.

Under the regulations for M.B., C.M., Robert Stewart M'Kim, M.A., passed with distinction in Forensic Medicine.

The Royal University of Ireland.

The First Examination in Medicine, Autumn, 1905.—The examiners have recommended that the undermentioned candidates be adjudged to have passed the examination:—Frederick J. Ball, William Boyd, James T. Brady, James Byrne, John Cullen, Alexander J. Dempsey, John J. Dennehy, Michael G. Devine, Edmund C. Fawcett, Henry A. Gillespie, Blanche G. C. Griffin, William Hamilton, James J. Hanratty, Helen A. E. Hegarty, John F. Hill, John L. Jackson, Patrick J. Lydon, B.A., John M. McCloy, Arthur L. McCreery, Patrick McGinnis, Edward M. MacIlwaine, Samuel K. McKee, William Magner, Thomas P. Magnier Harold D. Manderson, Edward W. Mann, Arthur F. M. Mullane, Bernard F. M. Neary, Michael J. O'Connor, Jerome O'Flynn, Edward J. O'Kelly, Michael G. O'Malley, William R. M. Orr, David A. Rice, Thomas G. Rothwell, Thomas W. Ruttledge, William J. Smyth, William W. D. Thomson, Hill W. White, David V. S. Willis.

Notices to Correspondents, &c.

☛ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

MR. B. E. KIDD.—Your note came to hand after the journal was made up for press.

DR. CLARKE will receive a private note.

DR. HANA'S paper is marked for early insertion.

QUACK MEDICINES.

J. P. WOODWARD (Bath).—Liquozone killed a child, as was shown most clearly at a London inquest, but for all that its sale is not prohibited in the United Kingdom. You are quite right, we believe, in saying that in some part of the United States of America public reports are made upon proprietary preparations, stating in so many words if their claims are true or false. Germany has the formula printed on the label. The United Kingdom does nothing but pay the piper with a blood-toll and enrich the patent medicine vendors beyond the dreams of avarice.

R. E. C.—It is impossible to estimate at all accurately the blood pressure by the finger alone. Dr. George Oliver's new instrument for the purpose is well spoken of. There are many fallacies to guard against.

EDALJI SYMPATHISER (Birmingham).—The position of the Home Secretary to the extraordinary Edalji case has been most unsatisfactory. His release simply confirms the theory maintained by a great number of persons that his imprisonment marked another of those grave miscarriages that have disgraced our modern police and criminal system. If he committed the crimes he was insane.

ORKNEYS.—There is a vast amount of marine botany and zoology to be explored—the field is practically illimitable, especially in microscopical directions.

ERRATUM.—In the account of the Medical Exhibition in our issue of October 11th in noticing Messrs. Armour's valuable essence of pepsin the strength was inadvertently given as a drachm of pepsin to the ounce of essence, whereas it should clearly have been a grain to the drachm.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 18th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. H. L. Barnard: Clinique. (Surgical.) 5.15 p.m. Dr. R. Jones: The Relation of Epilepsy to Insanity.

POST-GRADUATE COLLEGE West London Hospital, Hammersmith Road, W).—5 p.m. Dr. Beddard: Practical Medicine.

THURSDAY, OCTOBER 19th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Card Specimens will be shown by Mr. C. Wray. 8.30 p.m. Presidential Address: Mr. P. Smith. Papers:—Dr. Edridge-Green: Colour Systems.—Mr. C. Marcus: Notes on a Peculiar Pupil Phenomenon in Two Cases of Partial Iridoplegia.—Mr. S. L. Johnson: A New Form of Spectacle Lens which is Free from some of the Faults inseparable from Ordinary Lenses used in Vision (invented by Dr. Tscherning of Paris).—Mr. L. Paton: The Value of the Opsonic Index for Tubercle in Phlyctenulæ (preliminary note).

CHILDHOOD SOCIETY AND THE BRITISH CHILD STUDY ASSOCIATION (Parkes Museum, Margaret St., W.).—7.30 p.m. Annual General Meeting of London Branch of British Child-Study Association. 8 p.m. Hon. Sir John Cockburn K.C.M.G.: Address. (Arranged by the British Child Study Association.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC, (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. G. H. Savage: Climacteric Insanities.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. R. H. Cole: Intemperance in Relation to Mental Diseases.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square W.C.).—6 p.m. Dr. M. Dockrell: The Treatment of Eczema, in all its Forms. (Chesterfield Lectures).

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. J. E. Squire: Pulmonary Tuberculosis in Children. (Lecture I) (Post Graduate Course.)

FRIDAY, OCTOBER 20th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5.30 p.m. Cases and Specimens will be shown by T. R. Whipham, Dr. G. A. Sutherland, Dr. G. Carpenter, Dr. E. Cautley, Mr. P. L. Mummery, and Mr. W. Milner Burgess. Short Communications:—Dr. J. E. H. Sawyer (Birmingham): Diffuse Angeioma of the Liver (lantern demonstration).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. H. W. Dodd: Clinique. (Eye.)

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. Russell: Nephritis. (Lecture I.).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Opening Lecture of Winter Session:—Dr. P. Kidd: Pericarditis and its Effects.

Vacancies.

Lunatic Hospital, The Lawn, Lincoln.—Assistant Medical Officer. Salary £100 per annum. Applications to the Medical Superintendent.

Cornwall County Asylum, Bodmin.—Junior Assistant Medical Officer. Salary £135 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Portsmouth Borough Asylum.—Assistant Medical Officer. Salary £150 per annum, with board, lodging and washing. Applications to the Medical Superintendent.

County Lunatic Asylum, Lancaster.—Assistant Medical Officer. Salary £150 per annum, with board, lodging and washing. Applications to the Medical Superintendent.

Warneford Hospital, Leamington.—House Surgeon. Salary £100 per annum, with board, washing and apartments. Applications to the Secretary.

Bristol Royal Infirmary.—House Surgeon. Salary £100 a year, with apartments, board and laundry. Applications to W. E. Budgett, Secretary and House Governor.

Bradford Royal Infirmary.—
House Surgeon. Salary £100 per annum, with board and residence.
House Physician. Salary £100 per annum, with board, and residence.
Applications to William Maw, Secretary, Royal Infirmary, Bradford.

Appointments.

BRIMACOMBE, R. W. M.D.Brux., Pathologist to St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.

CROSLAND, G. W. **KILNER**, M.R.C.S., L.R.C.P.Lond., Medical Officer of the Huddersfield Elementary Schools.

DRAKE, JOHN ALEXANDER, M.B.Lond., M.R.C.S.Eng., L.R.C.P.Lond. to the Medical Staff of the Tenby Cottage, Hospital.

KNUTHSEN, **LOUIS** F., M.D., C.M.Edin., Permanent Clinical Assistant to St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.

PIRRIE, R. R. M.B., B.S.Durh., Medical Officer to the Post Office at Ryton including Greenside.

SWAN, R. H. J., M.B., F.R.C.S., has been promoted from Surgical Registrar to third Assistant Surgeon at the Cancer Hospital London.

Births.

WHITELEY.—On Oct. 11th, at 50 Britannia Road, Fulham, S.W. the wife of D. F. Whiteley, L.R.C.P.Lond., M.R.C.S., of a daughter.

Marriages.

BROOKHOUSE—FREEMAN.—On October 14th, at St. Andrew's Church. Highgate, London, Charles Scott Brookhouse, L.D.S., son of J. O. Brookhouse, M.D., M.R.C.P., of Nottingham, to Bessie Bidgood daughter of the late Thomas Charles Freeman, of Highgate

FERNIE—LYLE.—On Sept. 11th, at Christ Church, Vancouver, B.C. William Lewis Fernie, only son of the late Henry Mortlock Fernie, F.R.C.S.Edin., of Macclesfield, to Mary Isobel third daughter of the late William Vacy Lyle, M.D., Westbourne Square, London, and of Mrs. William Vacy Lyle.

HAWARD—MANN.—On Oct. 12th, at St. John's, Ealing, Walter Haward, M.B., son of the late H. T. Haward, of Ealing, to Louisa Ayton (Lulu) second daughter of the late James Ayton Mann, and of the late Mrs. Mann, of Ealing.

HUGGINS—BLOFELD.—On October 14th, at St. Mary Magdalene South Bersted, Bognor, Leslie Owen, third son of S. T. Huggins M.R.C.S., L.R.C.P., 32 Compton Terrace, Highbury, to Ellen (Nellie), eldest daughter of James Blofeld, Fortuna, Bognor.

LUCAS—DUNCAN.—Oct. 12th. at St. Mary's, Harrow-on-the-Hill, Charles Arthur, eldest son of the late Stanley Lucas, Esq., to Lilian May, youngest daughter of Henry Montagu Duncan, Esq., M.D.Lond., of Camperdown, Harrow-on-the-Hill.

Deaths.

FIELD.—On Oct. 11th, at 8 Belmont, Bath, Ernest Field, M.D., M.R.C.S., L.R.C.P., aged 54 years

HALSE.—On Oct. 12th, Charles S. Halse, M.D., late of New Bridge Street, and Suffolk Street, Pall Mall, London, aged 72 years.

SMITH.—On Oct. 12th, Lieut.-Colonel Maurice H. Smith, late Indian Medical Service, only son of the late Henry Spencer Smith, F.R.C.S., aged 55.

TENCH.—On Oct. 12th, at 67 Pernham Road, West Kensington, Edward Beavan Tench, M.R.C.S., etc., formerly of Wickham Market, Suffolk, in his 77th year.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, OCTOBER 25, 1905. No. 17.

Original Communications.

FOUR YEARS' HOSPITAL ABDOMINAL SURGERY. (a)

By BEDFORD FENWICK, M.D.,
Physician to The Hospital for Women, Soho Square, London.

It has occurred to me that it might be of interest to collate the cases of abdominal surgery which have come under my care during the last four years in The Hospital for Women, Soho Square, and I would fain hope that a similar course may be followed by other Fellows of this Society, because there are obvious advantages in dealing with hospital patients which appear to me to deserve more attention than this class of work has usually received. For statistical purposes, and for consideration by a scientific society, it is needless to say that the strictest accuracy is essential, and it is possible in dealing with hospital patients to quote chapter and verse, and thus to invite investigation in a degree which is quite out of the question in the case of private patients. Then, again, there is the, to my mind, further and inestimable advantage that all one's work in a special hospital is performed under the close inspection of experts. Any mistake in diagnosis at once becomes obvious on the operation-table; any mistake in technique is proved at once by the infallible test of results; and finally, in the case of any fatality, the *post-mortem* is made, and the records are signed by an independent and expert pathologist. It is unnecessary to emphasise the differences which exist in private practice, and my first point will doubtless be accepted—that, for the purposes of statistical inquiry, it is preferable that only hospital records should be employed. In this paper, therefore, I propose to deal solely with patients who have been operated upon by me in The Hospital for Women, and as I shall have occasion to point out hereafter, I am still further encouraged in this limitation because the results I have obtained in private practice have been better than those which the following records show—a fact which may be due to a simple reason. In a hospital, the patient has been admitted, as a rule, because her local or general condition disables her from performing her ordinary domestic duties, or earning her livelihood by following her usual occupation. In practically every case, rest and home care is impossible for her. It is essential that she should be cured as speedily as possible, and, therefore, for every reason she desires that any operation which can conduce to her speedy relief or cure shall be performed. Consequently, whatever the other physical conditions may be, if the abdominal disease be very serious or disabling, the chance of an operation is, except in very rare instances, offered to the patient, and is still more rarely, in our experience at Soho Square, refused by her. It is important to remember this fact in its bearing on the results of operation; because one is thereby led to operate on the worst-looking cases, even if the kidneys appear to be more or less unsound, even if the liver be more or less diseased, and still more often if the heart be more or less affected. On the other hand, in private practice, one has totally different conditions to deal with. The patient is not, as a general rule, dependent for her daily bread upon her own exertions; she can afford to take the necessary rest and give palliative measures a fair trial; so, if the heart be much affected, or the kidneys markedly inefficient, the tendency of course, is to postpone any operation of a serious nature altogether, or, at any rate, as long as possible. Consequently, I maintain it is not surprising when one finds that one's private practice shows a larger percentage of recoveries after operations than is obtainable when one has done these under the more disadvantageous conditions to which I have alluded, upon women, moreover, more or less enfeebled by illness, by want of proper care, and too often by want of proper food. I desire to emphasise this argument, because it will be observed from the following records, against each of which I have placed the Hospital Register Number, to permit of its easy identification, that nearly all the fatal cases in my list resulted from causes altogether extraneous to the abdominal disease and independent of the operation adopted for its cure.

The records begin with the first abdominal section I performed at The Hospital for Women after being appointed on March 1st, 1901, to the full charge of wards, and continuing for four complete years, that is to say, down to the end of February of the present year. The total number of cases upon which, during that period, I have performed abdominal section were 181. These include 54 cases of hysterectomy, mostly for fibroids of every kind and description, from soft myomata barely larger than the normal uterus, such as one I have exhibited at a meeting of this Society, and in which the cavity was so studded with bleeding growths that the patient was admitted into the hospital absolutely blanched and almost pulseless from the constant and profuse losses, up to large calcareous fibroids which completely filled the abdominal cavity, and were moulded into the pelvis, and which weighed nearly fifty pounds. The cases include 118 operations for the removal of diseased appendages, the majority being large pus tubes, closely adherent to the uterus, to the floor of the pelvis, and to the surrounding intestines, many of them embedded in dense inflammatory effusion, so that no inconsiderable difficulty was experienced in dissecting out the diseased tissues from their secondary inflammatory deposits. These cases, also, of course, include several patients suffering from ectopic gestation, most of whom were admitted in a condition of more or less collapse from shock or internal hæmorrhage. The list includes three cases of exploration in which the tumour was found to consist of malignant growths so deeply involving the intestines that their removal was impossible. It includes three cases of ventral hernia occurring at the site of abdominal operations performed by some other operator some years previously, and it includes three cases of hysteropexy for the cure of extreme prolapse. With regard to the two first classes, I will make a few observations directly, but with regard to the results, and especially in view of what I said at first, the records show that nine cases, that is to say, those in which malignant disease was found, whether this were removed or not, were discharged as relieved or unrelieved, that of the 181 cases of removal of the appendages, three patients died, and 115 were discharged cured. That of the 54 cases of hysterectomy, three patients died, and 51 were discharged cured. And of the other operations to which I have referred, all the patients were discharged cured.

(a) Read at a Meeting of the British Gynæcological Society on October 12th, 1905.

In brief, therefore, out of 181 cases, six patients died, and it is of much interest to observe the cause of death in each case.

In 1901, one patient died. She had pan-hysterectomy performed for malignant disease of the cervix. She was so ill that I advised her to have no operation, especially as she had far advanced tricuspid and mitral disease, consequent upon rheumatic fever many years before. She, however, pleaded so earnestly for any chance of recovery that I operated. She did fairly well for four days, and then collapsed, dying on the fifth day, and Professor Dalton's report upon the case was that the cause of death was advanced stenosis of the tricuspid and mitral orifices, and heart failure; the abdominal wound and pelvis being healthy. I think it will be admitted, therefore, that in this case the fatality had nothing to do with the hysterectomy.

In 1902, two patients died. The first I have already given in detail in a previous communication to this Society (May, 1902). It was an interesting example of cystic degeneration of an old-standing fibroid growth of the uterus, the patient being sixty-one years of age, and unmarried. The tumour consisted of two distinct parts, the upper part, which was degenerating, extended nearly to the ensiform cartilage, and on the anterior surface the intestines were widely adherent, and were peeled off with some difficulty; the lower part of the tumour was moulded into, and almost fixed in, the pelvis. Hysterectomy was performed, and the patient did very well for nine days. On the tenth day, she had some diarrhœa and violent vomiting. The abdominal walls were extremely fat, and between the umbilicus and the ensiform cartilage the wound tore open with the violent straining, and the intestines protruded. The wound was at once re-sutured, but a few hours later her heart suddenly failed, and she died. At the *post-mortem* it was found that the uterine stump was perfectly healthy and well-healed, and I showed the heart and microscopical sections at the meeting of the Society as a perfect specimen of fatty degeneration of the muscular walls. Death, in fact, was due simply to the heart disease. The second patient was fifty years of age and a widow. She had hysterectomy performed and a very large fibroid tumour removed. She had advanced mitral disease and three days after the operation suddenly collapsed. Her temperature never rose above normal, but she had several rigors, and died early on the fourth day. Prof. Dalton's report of the case was mitral disease, infarcts in the kidney, uterine stump and abdominal wound healthy. Once more, I think it will be admitted that the operation had little or nothing to do with the cause of death, in either of these cases. It is a curious coincidence that these two patients died within three weeks of each other.

From May, 1902, to January, 1904, I did not lose a single patient, and then, as punishing me for that prolonged good fortune, in 1904 I lost three patients; and, for the second time, two of these patients died within three weeks of each other.

The first was a case in which I removed a very large, suppurating broad ligament cyst, and, by some means, the intestines must have become infected, because she developed, on the second day, the ordinary signs of septic peritonitis, collapsed rapidly, and died within a few hours; and at the *post-mortem* the ordinary conditions were found.

But the next two patients were instances of the ill-fortune which will attend everyone in a long series of cases, however careful he may be. The first was a patient, aged forty-four, a widow, from whom I had removed two large pus tubes, from which she seemed to recover very well. The stitches were removed on the ninth day, and the wound was perfectly healed. But on the eleventh day after the operation her temperature suddenly ran up to 102°, she developed double pneumonia, and in spite of everything we could do she succumbed two days later.

The third case was even more unfortunate. She was a patient, aged fifty-one, from whom I removed a very large left ovarian cyst. She had old mitral disease, but recovered perfectly; the stitches were removed on the seventh day, the wound was found strongly healed, and she seemed to be perfectly well. On the seventeenth day after the operation, she was allowed out of bed, and was being helped to a chair, when she suddenly gasped and fell forward, and being lifted back into bed, was found to be dead. The *post-mortem* showed that there was a pulmonary embolism, the pelvis and abdominal wound being perfectly healthy and healed.

Between April 23rd, 1904, and the end of February last I did not lose another case, and I think I may therefore claim that the true mortality of these 181 cases was only one—that is to say, the case of septic peritonitis—inasmuch as that was the only instance in which death resulted from causes in any way connected with the operations performed.

I understand that my colleagues have not abstracted the notes of their cases in the manner which I have been led to do, in order to prepare this paper, but I can quite believe that their results must have been equally good, if not better than my own. On the basis, however, of these statistics, which I may repeat cover a consecutive period of four complete years, and including every abdominal operation performed by me in The Hospital for Women during that time, I may fairly claim that the results are sufficient to prove some important lessons. The list included 54 cases of hysterectomy and even if the patients who died from definite heart disease be excluded, the mortality in the remaining 51 cases was *nil*. I submit that this fact, if it stood alone, would be sufficient justification for the argument that cases of fibroid tumours of the uterus can safely be operated upon, with our present methods, at a less risk of life to the patient than is generally involved in leaving the tumour alone. I frankly admit that if the percentage of mortality after hysterectomy were considerable, it would be questionable whether a patient should be subjected to that direct and immediate risk; but when one remembers not only the usual consequences of these tumours upon the patient's health, but also the increasing risk to her life as she grows older, I maintain strongly that it is not justifiable to permit those dangers to life and health to continue when they can be prevented by a radical operation, with so excellent a prospect of recovery. I speak the more strongly upon this subject because I have seen many cases in private practice in which patients have been reduced to the last extremity, either by floodings or by the effects of pressure on the rectum or the ureter, but who have been permitted to continue for years in ill-health and danger through the mistaken views of their medical advisers. There is even to-day an archaic superstition prevalent among our profession that at the menopause all fibroid tumours cease to be harmful, that they atrophy and even disappear, and that if the patient can only survive until that millennial date, she will thereafter be relieved from danger and even from discomfort. How such a mythical superstition can have originated it is difficult to understand, but it undoubtedly persists to the present day. I have seen a patient this week who was known for years to suffer from a fibroid tumour, who was told twenty years ago by a distinguished obstetric physician that an operation was far too dangerous in her case to be advised. It is true that the mortality then was considerably greater than it is at present; but the result was that this woman was an invalid for twenty years, with a tumour evidently enlarging steadily the whole time, until, when I saw her first three months ago, it completely filled the whole abdomen, and was moulded into the pelvis. She was fifty-two years of age, the periods continued at intervals of a fortnight, lasting each time from a week to ten days, and more or less profuse, with the natural result that she was utterly blanched and unable to take the slightest exertion. Six months ago, she consulted a well-known physician for increasing abdominal pain, which he informed her was only due to the pressure of the tumour, and that when she was a little older this would begin to shrink, and then the pain would disappear. As various other doctors had promised her exactly the same results for the past twenty years, she became a little doubtful as to whether the prediction would be fulfilled whilst she was alive. When I saw her, I advised immediate operation on the ground that degenerative changes setting up local peritonitis were the cause of pain, that within a few months general sepsis would follow, and that it would then be too late to do anything for her. She was wise enough to consent to operation, and on removing the mass it was found that there were several large cysts just below the capsule of the anterior surface full of gelatinous material, and in one cyst the fluid was black and liquid blood. The intestines were adherent, as is so often the case, over part of the surface above the degenerated area, and it is quite certain that she could not have lived very long. She recovered without a bad symptom, and when I saw her this week she described herself, with some truth, as "a new woman."

Probably everyone in this meeting knows of similar cases, and will agree with the opinion I venture to express, that the time has come when definite principles should be clearly laid down as to the actual results and dangers of fibroid growths of the uterus. I am anxious not to be misunderstood. No one can be more averse to unnecessary operations than I am; but, without hesitation, I declare my firm conviction that when a uterine fibroid has become large enough to fill the pelvic cavity, or to rise in the central line half-way from the pubes to the umbilicus, and the patient is over forty years of age, the sooner hysterectomy is performed the safer for that patient and the better for the reputation of her medical adviser. From twenty years' experience and dissection of fibroids, I maintain that in such cases as these there will in more than 90 per cent. be a steadily increasing growth of the tumour. It will either invade the uterine canal, and set up vascular changes there, resulting in more or less prolonged losses, or it will extend outwards and press more or less injuriously upon the pelvic or the abdominal viscera. I am convinced that very few general physicians can be aware of the fact that the pressure of a fibroid growth of the uterus often exercises a most injurious pressure upon one or both ureters, and this leads to such constriction of their canal, and such dilatation of the pelvis of the kidney, that more or less complete destruction of the renal tissue may follow. I well remember some years ago, seeing a lady who complained chiefly of lumbar pain and very scanty urine, and in whom I found that the pelvis was completely filled with a uterine fibroid, whilst both kidneys felt distinctly large and tense. I advised operation as speedily as possible, but she consulted some well-known men in London, two of whom told her there was nothing to operate upon, and one, a well-known gynæcologist, advised palliative treatment. About three years later, I saw her again, as the latter gentleman had now advised an immediate operation, and in consultation with him I pointed out that there were distinct tense swellings in both renal regions. He, however, operated and removed the tumour, and the patient died twelve hours after; the *post-mortem* showing that both kidneys were merely bags of urine with very little healthy organic tissue left.

A good many years ago, I showed both at the Pathological Society and at a meeting of this Society, that the presence of large abdominal tumours produced a fatty degeneration of the muscle of the heart wall, which explained the sudden deaths which the older medical writers described as the remarkable termination of these cases. This fact, which I believe is now generally admitted, supplies another cogent reason for early operation upon these fibroid growths.

But there is still another argument to which comparatively little attention has hitherto been drawn, and which, more perhaps than any other, goes to disprove the antiquated superstition that fibroids cease to be noxious after fifty years of age. I am able from some hundreds of dissections confidently to assert that after fifty years of age there is a great and increasing tendency to the occurrence of degenerative changes in fibroid tumours of the uterus. If the tumour grows subperitoneally, the larger it becomes the greater is its loss of blood supply when the menopause causes ovarian atrophy; and, as I have pointed out, in various cases shown before this Society, the question of the blood-supply is the determining factor in the healthy condition, or the degeneration, of a fibroid tumour. So that, when the arterial connection is reduced to the minimum, the growth becomes calcareous; if the pedicle become twisted, and the blood supply be suddenly cut off, hæmorrhages into the substance and rapid cystic changes follow; and, between these two conditions, lie all the varying degenerative changes with which those who have seen many of these cases are so well acquainted.

But the cardinal rule which I would venture to define is, that as soon as degeneration of a fibroid begins, active danger to the patient must follow; localised inflammatory changes invariably commence, pain becomes a constant and increasing symptom, and adhesions, more or less difficult to deal with, are a necessary consequence. I maintain that an ordinary healthy fibroid is never painful, and that when pain in such a growth occurs and persists, in ninety-nine cases out of a hundred degeneration of the growth has commenced; and the sooner that patient is operated upon the safer it will be for her.

Finally, I am sure that very few general physicians are aware that after fifty years of age fibroid tumours fixed in the pelvis, by losing the full blood-supply they have received during the time of active menstrual life, almost invariably degenerate, and that if such patients are left to Nature, a general septic infection sooner or later occurs. In such cases, I have generally found that the adhesions between the rectum and the tumour were very close, and that the contents of the fibroid were most offensive in odour; and this fact may not improbably explain the rapid depreciation which takes place in the patient's general health.

I venture to consider that there are certain general principles which this Society could do immense service to the medical profession by enunciating, with all the authority which it naturally possesses.

First, that a fibroid tumour of the uterus in a patient aged forty and over, which fills the pelvis, in the great majority of cases exercises dangerous pressure on the rectum, bladder, or ureter, and should therefore be removed.

Secondly, that in such a patient a fibroid tumour which extends centrally half-way to the umbilicus and is nodular on the surface and hard, should also be removed as soon as possible, because in the great majority of cases it will sooner or later undergo degenerative changes, dangerous to the life of the patient.

Thirdly, that where the patient suffers from frequent and prolonged losses, unchecked by rest or medicine, where the uterus is enlarged and nodular to the level of the pelvic brim, hysterectomy should also be performed, as the safest and most certain cure of the condition.

I would like to make a few remarks with regard to the cases of tubal disease on my list; and, again, would point out that, excluding the two cases of death from lung disease, there remain in the list 116 operations for the removal of more or less complicated tubal and ovarian growths, with only one death. I submit that this fact also proves that these cases can be operated upon with infinitely greater safety to the patient than is involved in the risk to her health and life by any less radical treatment. I need not dwell so much upon this subject, because the profession is—thanks in no small measure, to the work of this Society—better acquainted with the dangers, and I may add, with the diagnosis, of tubal and ovarian disease, than they were fifteen or twenty years ago, and that they therefore realise more keenly, than was formerly the case, the cardinal necessity of operative treatment for such patients.

I feel that I have already trespassed too long upon the attention of this meeting, but I cannot refrain from adding a few words on one or two practical points in the after-treatment of these cases, and upon the technique of abdominal operations generally.

In the first place, I have entirely given up two measures which were much vaunted a few years ago. I mean washing-out and drainage. I have never been able to satisfy myself what good result could follow from washing-out. A soft sponge on a holder will remove all the blood or fluid which there may be in the pelvis, and I have often watched other operators flushing out the abdominal cavity, and washing up pus and blood below and upon the intestines and up to the diaphragm, and wondered how they were going to remove it afterwards—as, of course, they could never do. The general plan I have followed has been to pack off with gauze or Billroth's cambric the intestines and all tissues around any septic-looking tumour before touching the latter, and to cleanse any surface which may have been touched by pus with as absolute care as possible. With regard to drainage, the only cases in which I have found it necessary is where a large purulent or septic growth has been removed from the broad ligament. In such cases, I have made an opening direct into the vagina, and so obtained drainage from the lowest point. Whether I am right or wrong in my theory, at any rate I now never attempt to drain a patient against gravitation through the abdominal wound; and, after all, I may plead that nothing succeeds like success.

With regard to the after-care of the patient, I am sure that an immense amount depends on one's own personal oversight. The more I operate on abdominal cases, the less am I surprised to find something I never expected to find, in the cavity; the less am I surprised at the extraordinary complications which will follow the simplest case; the less do I feel inclined to regard any case as trivial until the patient is absolutely convalescent. The moment the pulse begins to quicken, after the second day, I give calomel and salts, and if necessary an enema. If there is marked dulness of the first sound at the heart's apex, I start stimulants and strychnia at once, for there can be no obvious reason for waiting till the heart shows signs of failure. My patients have gas and ether as an anæsthetic, especially if the heart is at all weak, rather than chloroform, unless there is a tendency to chronic bronchitis or other lung trouble, in which case chloroform is used, generally with a strychnia injection. When there has been much loss of blood, or the patient is very collapsed, I put one pint, or even two, of hot water into the peritoneal cavity before commencing to sew up the wound; and it is interesting to observe that in many such cases, in five minutes the patient's pulse has fallen by many points and become well-filled.

With regard to after-diet, I never give the patient a mouthful of anything for twenty-four hours, and only milk and tea and bread-and-butter until the bowels have acted. I am quite sure that formerly we lost patients because we fed them too early and gave them too much. I am firmly convinced that the best way to cause secondary oozing from torn adhesions is to fill the patient's veins with fluid; and that the best way to dry the pelvis and the peritoneum, and so secure rapid healing, is to make the vascular system—and the patient—deadly thirsty.

It would not be right for me to conclude without formally but sincerely expressing my conviction that much of the success of the operations to which I have referred must be ascribed to the skilful and ever resourceful assistance which it has been my good fortune to receive from my friend and colleague, Dr. Simson, and to the zeal and carefulness with which my abdominal cases have been nursed by the various Sisters in charge of my wards, and by the nurses working under them, at The Hospital for Women.

INFANTILE MORTALITY AND INFANT MILK DEPOTS. (a)

By W. J. THOMPSON, M.D., F.R.C.P.I.,
Physician to the Hospital.

After some introductory remarks, the lecturer said: When we consider the number of children—I refer now more particularly to those up to the age of one year—that come under our observation both in the wards and dispensary suffering from different diseases and disorders we cannot but feel saddened when we know that a great number of these affections are preventable. Is it any wonder, then, that the death-rate of infants is so high? From the Registrar General's Report of last year we find that the average death-rate for 76 great towns of England and Wales was 17·2 per 1,000, while the mortality of infants (under one year old) was 160 per 1,000 births, an average of almost one in six—in other words, out of every six children born one child dies before it reaches the age of twelve months. In certain large towns the death-rate was even higher—in Birmingham 197 per 1,000 births, in Preston 218 per 1,000 births; in London the highest borough rate was Bermondsey, which was 172 per 1,000, and the lowest was Marylebone with only 94 per 1,000. Through the courtesy of the Registrar-General, Dr. Ninian Falkiner has kindly supplied me with returns from which it is seen that the average infant death-rate for Dublin for the past two years is slightly above the average for 76 large English towns—162·5 per 1,000 births. It is higher than Belfast with 144 per 1,000 births, and much higher than Cork with 116 per, 1,000 births. The average death-rate for Dublin for the same period is about 24 per 1,000, and about 20 for Belfast and Cork. As stated previously, these figures refer exclusively to large towns and cities, and not to rural districts. It is also a recognised fact, although no statistics on the subject are available, that illegitimacy doubles or even trebles the chance of an infant dying before its first birthday. Bailie Anderson, Convener of the Public Health Committee, Glasgow, stated in a paper read before the British Medical Association this year in Leicester, that in investigating this matter he communicated with the Consuls of sixty of the leading cities of the world, and he found in such places as Buenos Ayres, Barcelona, Stockholm, and Christiania that the infant mortality was much less than in England or Scotland. It is a remarkable fact, pointed out by Dr. Arthur Newsholme, Medical Officer of Health for Brighton, that whereas for the past half-century there has been a marked decline in the general death-rate of the community, about 16 per cent., the infantile mortality has remained stationary. Medical Officers of Health in their annual reports are constantly drawing public attention to this matter, and some of them in very forcible language. For instance, Dr. H. Henwood, Medical Officer of Health for Stoke Newington, stated recently in his annual report that "if the death-rate amongst calves was only one-half of that which prevails amongst infants, the farmer would before long have to entirely give up the business of rearing cattle."

This high mortality amongst infants is a question of extreme importance, both from a public health point of view and from the physical deterioration aspect, of the latter of which we are at present hearing a great deal—and deservedly so. We must not forget that while thousands of infants perish annually, there are thousands of others who barely survive, and these later on, when they face the hard struggle for existence, grow up both mentally and physically weak, and it is from this class that our charitable institutions and asylums are being filled, and, indeed, in many cases overcrowded. Tuberculosis in its different forms, and emigration, deprive our island of a great number each year of what may be said to be the flower of our people, but the high death-rate amongst infants, and the weakness and debility contracted during the first year of life, take another large slice off our population. Is it any wonder, therefore, that our population is steadily decreasing? A great move has been made, and we are all pleased to know with some success, to diminish the ravages of tuberculosis by the open-air treatment, isolation, and such like; and just at present efforts are being made to foster home industries, to improve our agricultural products, and in other different ways (we all sincerely hope these efforts will be crowned with success), and so try to prevent the drain of emigration. Although very much has been done in England and Scotland, and in, I may say, every country in Europe and in the United States, not as much has been done as might directly be done in our city to try and remedy this evil of high infant death-rate. As citizens of the Metropolis, we trust that Dublin may make a movement in this matter, for we know from experience that our citizens are always first to undertake anything philanthropic and charitable.

(a) An Address delivered at the Opening of the Medical Session at Jervis Street Hospital, Dublin, on October 17th, 1905.

We may, perhaps, first inquire what are the causes of this enormous infantile mortality, for I have shown that it is prevalent in all large towns. The causes are exceedingly numerous and varied, but it is universally admitted that improper artificial feeding is the most important factor, owing, no doubt, to the unfortunate decline in breast-feeding. We have also got overcrowding, insanitary surroundings, tenement dwellings, ill-health of one or other of the parents, and many other like reasons. It is computed that fully three-fourths of the deaths of children under twelve months old occur amongst those who are artificially fed. By artificial feeding I mean any feeding other than the mother's milk. One other recognised fact is that the high death-rate is practically confined to the working and lower classes, the infant death-rate amongst the upper and middle portion of the community is about normal. This great mortality and widespread production of disease can be to some extent prevented by the mothers nursing their babies, and, failing this, by the proper use of pure cows' milk. The former method we may call Nature's method, is the one to be recommended if at all possible, for the latter method is only a makeshift. In the year 1901, the Council of the Dublin Sanitary Association investigated this matter very carefully, and from their report it is shown that out of a total of 108,398 infants' deaths in the ten years, 1889 to 1899, no less than 62,583 of the deaths, or more than one-half, were due to diseases which in the ordinary course are attributable to the result of improper feeding.

Human milk is by far the best food for infants. It is Nature's food, a unique and wonderful food, for which the science of man has up to the present been unable to manufacture even a secondary substitute. As Dr. M'Cleary, Medical Officer of Health for Battersea, scientifically puts it:—"Although physically the child is separated from the mother at birth, physiologically separation only takes place at weaning, and so, from a physiological standpoint the artificially-fed baby is a premature child, and anything but maternal nursing is foreign to its digestion." Besides, it is found that the blood of a breast-fed infant has a greater bactericidal action than that of the hand-fed, and it is our clinical experience that suckling infants have a marked immunity from infectious diseases. Dr. Hope found that in Liverpool the deaths from diarrhœa "amongst children under three months old, either wholly or partially fed on artificial food, are fifteen times as great as they are amongst an equal number of infants fed on the breast." Undoubtedly, as regards infant feeding, Nature is, for so far, superior to art. The point therefore is, as far as we can, to take Nature for our guide.

The mother who is unable to breast-feed her infant has to make a choice of what she should substitute for human milk, and she finds that she has three classes of food to select from:—(*a*) Preparatory foods, in great variety; (*b*) condensed milk; (*c*) cows' milk, more or less modified. It is at this period that the medical practitioner can do a great deal if consulted; but unfortunately his advice is seldom if ever sought for until the baby becomes seriously ill, and treatment becomes necessary. If only parents and people generally could be got to understand as Dr. Chaplin points out, "that anything aside from breast milk that is put into an infant's stomach is a foreign substance," they would see that it is necessary to obtain a substitute as closely as possible to human milk.

Of the three substitutes just mentioned both the consensus of public opinion and clinical experience, as has been demonstrated in the working of infant milk depots, goes to show that cows' milk properly cared and modified is the nearest approach we have at present to human milk. I have said properly cared, and by that I mean the care milk receives from the time when it leaves the cow's udder until it reaches the child's stomach. You will agree with me that during this period milk is subjected to contamination. Take, for instance, the ordinary process that goes on, say at this season of the year, amongst a large proportion of dairy cattle. The cows are at grass; they are never groomed; their udders are dirty; the milker may possibly not have washed his hands before commencing, or may have a septic cut or wound about his fingers; he goes from one cow to another, and so carries with him dirt, epithelium, dust, germs, bacteria—and, as Dr. Leslie Mackenzie, Medical Member of the Scottish Local Government Board, describes it—"the various dirts of the civilised human are at every hand reinforced by the inevitable dirts of the domesticated cow." How can the milk escape being contaminated? And then it has to be conveyed to the city dairies, and delivered in the ordinary way, and during this time probably further contamination takes place. Municipal authorities prevent milk being diluted, and we all trust, I am sure, that they will have the power to inspect every dairy farm that sends milk into cities. Professor Sidgwick pithily describes the milk supply to Boston some years ago, thus:—"Public milk supplies may not be legally watered, but they may be stale, or polluted, or infected."

This class of milk is, unfortunately, the kind mothers frequently get for their babies. Is it any wonder, then, that in a short time the delicate stomach of the infant becomes upset? In this picture I have drawn I do not specially refer to Dublin—for we know there are quite a number of dairy farmers, and I believe this number is increasing, who are most careful about milking, the proper cleansing of vessels, carriage of milk, &c.—I speak of large cities generally, both in this country, the Continent, and America.

I.—A pure city milk supply is, therefore, one essential in proper infant feeding which will tend towards the decrease of infant mortality.

II.—Any improvements made for the health of the community living in tenements and congested districts also tends to diminish the ordinary death rate, and, as a matter of course, that of infants.

III.—It is found that when the temperature of the earth, four feet below the surface, reaches 56 degrees Fahrenheit, diarrhœal disease, which is so prevalent and so fatal, commences, and this in the months of July, August, and September. Through the initiative of Sir John Moore, M.D., Trinity College keeps a daily record of the temperature, and the Municipal and Urban Councils have taken action in this matter. It is to be hoped this move will have some influence in diminishing the high diarrhœal death-rate during these three months.

IV.—Our lying-in hospitals, some dispensaries, general hospitals, and private practitioners have printed instructions how to care the baby. These instructions are given to suitable cases, and in this way some good is done.

Suffering humanity owes a great deal to the initiative of the French medical profession, and it was in France, in the year 1890, that Professor Hergott first instituted an establishment for a supply of sterilised milk for those infants for whom breast-feeding was impracticable, so as to try to reduce the excessive death rate, as this question was of national importance on account of the unusually low birth rate. Other institutions with a similar object, but on a slightly different bases, followed, and in 1892, Dr. Variot opened the first Goutte de Lait in Paris. Two years later Dr. Leon Dufour established at Fecamp the first Provincial Goutte de Lait. These Gouttes des Laits in France correspond to what in England and Scotland are called "Infants' Milk Depots." They are simply dispensaries from which milk is distributed, modified to suit the age of the baby, to those mothers who are not able to breast-feed their infants, and who are in such circumstances and surroundings that they cannot afford out of their meagre livelihood any additional burden for the feeding of the baby. In some institutions those who take advantages of these are divided into three classes:—

1.—The Gratuitous—for the very poor.

2.—Half-payment section—for those who are able to contribute something.

3.—Paying section—for those who can afford to pay the full price, which includes cost of milk and cost of preparation.

Of course it is understood that these three sections receive the same quality of milk, or modified milk, as the case may be.

The following is the routine of the Infant Milk Depots in England:—

> 1.—The milk is got from a reliable source, and in most cases those who supply the milk are subjected to certain stringent regulations about the grooming of the cows, cleanliness in the milking process, cooling, properly prepared vessels to receive the milk, and rapid transport.
>
> 2.—The milk on arrival at depot is strained and filtered to prevent any mechanical pollution.
>
> 3.—It is then modified by the addition of water, cream, and sugar, so as to suit the age of the infant.
>
> 4.—After this process it is bottled, and the quantity in each bottle is likewise arranged for the age of the infant. The bottles being closed with stoppers, are placed in the sterilising chamber for a period varying from 15 to 30 minutes. When taken out the bottles are rapidly cooled in a cooling tank, and are then ready to be placed in wire baskets, which hold from six to nine each, and contain a 24 hours' supply for the infant. This is handed out or delivered, and next day the basket of empty bottles is returned and a fresh supply obtained. In France each baby is required to be brought to the depot at least once a week, when it is medically examined, weighed, &c. In this country, while this is strongly recommended, it cannot, as on the Continent, be enforced.

These infant milk depots are of two kinds—those under municipal control and those under private or philanthropic enterprise. In the year 1893 the Hon. Nathan Straus, a well-known philanthropist of New York City, established in a comparatively small way an "Institution to place milk suited for infant nutriment within reach of the poor." This has now become one of the largest, best managed, and best known establishments in the world. In 1898, under the guidance of Dr. F. Drew Harris, Medical Officer of Health, the St. Helen's Corporation, after a deputation had gone to France, visited several Gouttes des Laits, and were satisfied of the worth of these institutions, opened the first infant milk depot in this country. Depots were then rapidly opened, all under municipal enterprise, in Liverpool, Ashton-under-Lyne, Battersea, Bradford, Leith, Glasgow, &c. The first private depot in this country was established in 1903 in York, and in Finsbury in 1904. I have myself visited the infant milk depot in York. The greatest trouble and care was taken to show me the working of the institution, and I was very pleased with what I saw. It is situated in a poor district of the city, called Gillygate, which would correspond to Cork Street and its neighbourhood in Dublin. You may ask what have been the results of the establishing of these infant milk depots. The Hon. N. Hans, in an exceedingly interesting paper on the work of his institution in New York City, at the meeting of the British Medical Association this year, says "that in 1892, the year before I began the systematic prosecution of my work, the infant death-rate for the summer quarter reached the appalling figure of 136·1 per 1,000 of the population under 5 years of age. Last year the number was reduced to 74·5 per 1,000. In other words, had the infant mortality of the same quarter been reproduced relatively to the population in 1904, the number of deaths would have been 8,725 instead of 4,805. I do not think it is a hasty induction from the facts to claim that the most important element in the saving of these 3,920 infant lives has been the improvement of the character of the milk supplied to the children of the New York poor." The French physicians claim that there is a very great reduction in the infant mortality since the institutions were established. Dr. Drew Harris, of St. Helen's, states that in the year 1902 the death-rate of infants amongst the children receiving milk from the depot was 82 per 1,000 births, whilst the general borough death-rate was 167 per 1,000. Dr. Hope, Medical Officer of Health for Liverpool, in his annual report for 1903, states that the death-rate amongst the depot-fed children was 78 per 1,000 Dr. M'Cleary, Medical Officer of Health for Battersea, in his report for 1902 has the same pleasant statement to make.

The practical point is this, that if such institutions are carried out successfully, and are doing good work in France, Spain, Belgium, the United States, England and Scotland, could not such an institution be established in Dublin? There are two well-known facts in our favour—(1) No mother is so fond and devoted to her baby as an Irish mother; (2) no people in the world are so charitable as the Dublin people. With these two data I fail to see why something in the way of starting an infants' milk depot in the city should not be done. As matters are at present, our death-rate from infants under one year is enormous, almost one in six. In other countries and large cities an effort has been successfully made to diminish that death-rate. Nothing, so far, has been done in Dublin in this direction. Are we, who have such a name for charitable citizens, going to do anything?

A PECULIAR CASE OF RECTO-VAGINAL FISTULA,

By Dr. J. SPENCER SHEILL,
Assistant-Master, Coombe Maternity Hospital, Dublin.

Recto-vaginal fistulæ are sufficiently common in the gynæcological wards of our hospitals, but usually they have a definite and easily ascertained cause, the commonest, of course, being trauma during labour, and an attempt—only partly successful—to repair a complete perineal laceration.

The case I am about to describe differs from the majority in that the subject was a nullipara. I shall briefly state the principal points of interest.

Mrs. P. consulted me complaining of inability to control the bowels, especially when not constipated, chronic constipation being the rule with her. She stated that fæces and flatus would at times pass from her involuntarily, causing her much distress and inconvenience. She further stated that she *thought* that sometimes they would pass by the "*front passage*."

This state of affairs had been going on for the past five years, and her life was becoming unbearable to her; so, after much persuasion by her husband, she sought my advice.

The patient is a well-nourished, healthy-looking woman, æt. about 32, who states—to use her own words—that she has never known a day's illness in her life. She had been married eight years and had had no family; in fact, had never become pregnant.

On examination, the external genitals seem to be quite normal; the perinæum is intact; the fourchette also. There are no scars to be seen near either vulva or anus, no piles, and the anus seems normal. On further examination there is no difficulty in arriving at a definite diagnosis, for, on passing a bi-valve speculum into the vagina, the mucous membrane of the bowel can be seen protruding through an opening in the posterior vaginal wall about three centimetres in diameter.

On palpation, the opening is felt to be surrounded by somewhat brawny tissue, and is slightly irregular in outline. Three fingers can easily be passed through it into the rectum, one of which is painlessly slipped through the anus.

The fæcal fistula is situated in the anterior portion of the internal sphincter of the rectum just above the apex of the triangular perineal body.

It is a peculiar thing that the patient only "*thought*" that at times fæces was passed per vaginam; but any incontinence existing must have been due to the fæces escaping through the fistula as the external rectal sphincter is functionally perfect.

The obscurity of the etiology of the case is its most interesting feature. As we know, recto-vaginal fistulæ may be caused by trauma—either by injury during childbirth, or, rarely, by means such as falling on a pailing or a broken utensil. The undue pressure of a pessary, syphilis, malignant disease, peri-rectal abscess, tuberculous ulceration, and occasionally ulceration following infective fevers have all been noted as possible causes, but after the closest questioning, most, if not all, the above-mentioned causes must be excluded. The patient states that she never met with any injury, never was pregnant, never wore a pessary, never suffered any lasting pain, never bled unduly, or was troubled with leucorrhœa, and she has no specific history. Congenital malformation is excluded, as the patient was quite well up to five years ago. The only hint obtained as to the possible original cause of the trouble was unfortunately only gained after asking unavoidably leading questions. She told me that on one occasion a very violent coitus took place when her husband was under the influence of alcohol, and she experienced at the time a feeling as if "something had suddenly given way," associated with considerable pain.

For some days after this occurrence, a discharge of what she called "matter" came from the vagina; a little later this ceased and fæces and flatus were passed involuntarily, but she is certain that *some* fæces has always come per anum, so it is not a true case of "anus præternaturalis vaginalis."

It is difficult to believe that there could have been an abscess in the recto-vaginal septum as there was no pain except the momentary pain caused by the above-mentioned violence. Painless tuberculous ulceration is unlikely, for there was no chronic discharge previously, and no sign of tubercle elsewhere, and yet where did the flow of "matter" come from which she stated immediately followed the violence and remained some days?

Perforce I am driven to think that the fistula owed its existence to some form of painless suppuration in a patient subject to chronic constipation, and that the violence precipitated rupture of the abscess sac.

The difficulty of repairing such a large recto-vaginal fistula is well known; in my case it was increased by the narrowness of the parts. I performed a flap-splitting operation, and sutured the rent vertically in layers with "ten-day" chromic catgut, of a brand which experience has taught me could be depended upon to last eleven or twelve days.

All went well until the eleventh day, when a small amount of fæces came per vaginam; after that day no more came. On examination later I found a small fistula—less than one centimetre in diameter—remaining, but the rectal mucous membrane had fallen over it in the form of a flap valve making the recto-vaginal septum functionally perfect. This small fistulous opening might have been closed after a time by repeated cauterisation, but as the patient was anxious for a perfect immediate result I revivified the margins, and inserted three silk-worm gut sutures in the transverse direction this time, to avoid the separating action of the sphincter. On removing the sutures three weeks later the fistula was entirely closed.

THE IRISH MEDICAL ASSOCIATION ITS RE-ORGANISATION AND ITS FUTURE.

By JAMES CRAIG, M.D., Univ. Dub.,

Fellow and Registrar Royal College of Physicians of Ireland,
General Secretary Royal Academy of Medicine in Ireland,
Member of Council and of Committee of Council, I.M.A.

VI.

"Men were born to be serviceable to one another, therefore either reform the world or bear with it."

"Understanding does not always drive onward like an arrow. The mind sometimes by making a halt and going round for advice moves straight on none the less and hits the mark."

—*The Meditations of Marcus Aurelius.*

In attempting to express my views on the subject of the re-organisation of the Irish Medical Association, I have before my mind the absolute necessity and possibility of reform as well as the wisdom of considering the opinions that are set forth from different standpoints by those who interest themselves in the matter.

There is surely something wrong with an Association of the kind whose nominal membership is less than one-third of the medical practitioners resident in Ireland, and with this unquestionably short roll of members, it is small wonder that comparative failure should have been writ large over so many of the undertakings of the Association in the past.

An opportunity has now arisen to make the Association what it should be, a powerful instrument in protecting the rights of the medical profession, and in directing public opinion to secure legislation for the improvement of the health of the community. It must be a real Irish Medical Association not working for the benefit of any one class, and not controlled by any particular section of the medical profession.

I take it, therefore, that the purpose of re-organisation at the present time is to secure the adherence to the Association of the vast majority of the 2,632 medical practitioners registered in Ireland, and as a natural consequence of this to gain an added power from a united profession.

I would venture therefore to suggest that a broad based *policy* which will embrace the interests of every section of the medical profession in this country is as necessary for an universal adhesion of the profession to the Association as is the construction of a proper *medium* through which this wider policy will be carried into effect.

It is most essential that the purpose for which a special class of machinery is to be used should be taken into consideration during its construction. And as it is my own personal opinion that the

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(a) Being the sixth of a series of articles specially communicated to the columns of the Medical Press and Circular by prominent members of the Irish Medical Association.

interests of every individual member, severally and collectively, should be the care of the Association, it naturally follows that any scheme of re-organisation in order to be successful, should aim at providing a machine that would be capable of dealing with the widest apart and most varied interests. I trust I have made myself quite clear on this point, viz. : that if the Association is to be an effective force, it must adopt a wider policy than has been its aim in the past, and to carry into effect this broader policy it will be necessary to bring into existence an organisation capable of dealing with it.

It is scarcely necessary for me to elaborate fully the scheme that is in my mind for the achievement of these objects, but I shall without any claim for originality give in brief a general outline of it.

There should be a meeting of representatives held at the same time and place as the annual general meeting. Each of the thirty-five branches should send an elected delegate whose vote when required, should represent the number of members in his branch. At this meeting all members of the Association should have the privilege of joining in the discussions, but should have no power of voting. Matters to be discussed should be formulated by the branches or the council, and should be a sufficient length of time before all the branches to allow the delegates to receive the authority of those they represent for voting on such matters. In fact, no important departure of policy or matters affecting particular interests should be finally decided upon by the representative meeting until the branches had been given an opportunity of discussing and expressing their views upon them through their representatives. And most certainly the annual general meetings should have their scientific and social sides as well, which would interest many of the members and still not interfere with the important work of the representative meeting.

To carry out the decisions arrived at by the representative meeting an executive council would be necessary. The number should not exceed fifteen, and I would suggest that six of these should be chosen before the annual meeting by the vote of the entire body of members, that six others should be elected by the representative meeting from among themselves, and that the twelve members so elected should then co-opt three others whose suitability for the position was well-known. The council thus formed should elect one of their number as chairman.

Now it is perfectly obvious that much of the success of the re-organisation on the lines I am suggesting would depend upon the powers given to the council. It should be entirely responsible to the representative meeting whose decisions it should carry out, also it should be accorded the privilege of forwarding proposals to the representative meeting on due notice being given, as in the case of the branches, some three months before the date of the annual meeting.

The council should meet quarterly, or oftener if necessary, and in order to digest correspondence and prepare the business at least three committees of five members each would be necessary, say as follows :—A Journal and Finance ; a Parliamentary and a Medical Defence.

The Association has been doing a great deal of defence work in the past, let it in future undertake medical defence on a fully recognised and well-defined basis.

Every individual member looks to the value he will receive for his yearly subscription of one guinea. The establishment of defence in the programme of the Association, would give him encouragement in this direction. Then again, the Journal of the Association must be made of some value to each individual subscriber, and this leads me to the important suggestion that the general secretary should be a whole-time, well-paid official, who should be able to visit the branches in the capacity of an organiser, and if possible also should be able to edit the Journal; and why, in the name of all that approaches to commonsense, should the Journal not be run on the lines of existing medical journals ? Would it be impossible to find a young medical man capable of filling a post of the nature indicated ? If religion and politics could be eliminated from his qualifications I venture to think such an individual might easily be found who would be well worth a salary of from £300 to £500 per annum. I should allow the council to nominate him, subject to the approval of the representative meeting.

Finally, I suggest that the present system of holding the annual meetings in different centres should be elaborated so that every branch might in rotation have the privilege of being selected as a place of meeting if it so desired. This selection should be made a couple of years in advance and the branch so chosen should have the privilege of nominating the President of the Association for that year from among its own members.

The duties of the President as President should be limited to presiding at the annual general meeting, and the various functions in connection with it.

A good attendance of members at these meetings would secure an extensive exhibition of instruments and drugs, and the firms so represented would pay in rental a sum that might almost defray the expenses incurred by reason of the meeting.

EPITOME OF SCHEME.

1.—Annual meeting to be held in principal town of each branch in rotation, and lasting for two or perhaps three days : (1) Scientific ; (2) Social ; and (3) General Interests represented. President for year nominated by branch.

2.—Representative meeting attended by one elected delegate from each of the thirty-five branches. Chairman appointed from among the delegates at first meeting, afterwards by the delegates from among non-delegates. All matters affecting the honour, interests, and well-being of the profession to be discussed on three months' notice of motion from branches or executive council. Power to alter by-laws.

3.—An executive council of fifteen members, six elected by the entire body of the Association, six by the representative meeting, and three co-opted by the twelve elected members. One to be elected chairman. To meet quarterly, or oftener if necessary. Report to be controlled by the representative meeting.

Several committees to be formed so as to condense work.

4.—A general secretary and editor (preferably a young medical man) who would give his entire time to, and get well paid for this work.

5.—Medical defence to be established on a proper basis.

6.—The Journal to be conducted on the lines of existing medical journals.

If my scheme is utopian I claim pardon, but this much I do feel most acutely, that although at the present time the urgent need of Poor-law reform has created a considerable, but wholly inadequate interest, in the Association, when the time of redress of the just grievances of the Poor-law Medical Officers has been reached the Association will require a thoroughgoing policy of general usefulness if it is ever to attain the power one may reasonably hope it should possess.

If the membership were increased to 1,500 an income of a similar number of guineas yearly would put the Association in a position of comparative wealth. The delegates' travelling expenses should be paid. In my scheme about £50 a year would do this. The travelling expenses of the council should also be paid, and this should not cost more than another £50. So that with £300 towards the cost of the journal and £500 towards the salary of a general secretary and editor, the amount available for defence and other purposes should still be sufficient.

I have not before me a plan of the branches with the number of medical practitioners resident in each, but it is probable that a revision of the list, accompanied by alterations in boundaries, might be useful. To secure an energetic, earnest, and business-like secretary for each branch would do much to increase the membership and influence of the Association as a whole. Whatever be the outcome of the next General Meeting, of this much I am convinced—that we must all work together and drop recriminations.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting held October 12th, 1905.

Dr. William Alexander, President, in the Chair.

Specimens.

Dr. Bedford Fenwick: "A Remarkable Case of Pulmonary Embolism," for which we hope to have space in our next.

Dr. **Hodgson** asked if the embolus was examined, and whether it was possible that the anæsthetic caused detachment of an embolus owing to old heart trouble?

Dr. **Heywood Smith** thought the interest in the case arose from the condition of the patient's heart. It was generally acknowledged that deep pelvic operations, for some reason not known, seemed much more favourable to the production of embolism. Some years ago he had a patient on whom hysterectomy was performed, who, while sitting up in bed for luncheon a fortnight afterwards, fell back dead from pulmonary embolism.

Dr. **Inglis Parsons** asked whether there was a high temperature, and whether the clot started from the valve?

Dr. **Bedford Fenwick**, in reply, said the patient had a very bad attack of rheumatic fever twenty-five years previously, and had incompetence of the tricuspid orifice with thickening of the valves. On the valve in question there was a hard, calcareous outgrowth, the size of a split pea, from which the decolourised clot extended along the ventricle into the pulmonary artery, so that evidently it had been formed either during the operation, when her heart was placed as much as possible at rest, or directly afterwards, before she recovered from the anæsthetic, as it was eight hours before the ventricle and pulmonary artery became sufficiently obstructed for the nurse to notice the change in breathing. The embolism was a thickened cylinder, passing from the diseased valve through the ventricle and pulmonary artery, blocking both artery and branches. The temperature rose about eight hours after the operation to 102°, the breathing rapidly became quicker, and the pulse rose to 130. The patient died eighteen hours after the operation.

Dr. **Macnaughton-Jones** read the notes of a case of

primary tuberculosis of the fallopian tubes.

The patient, from whom the adnexa were removed, was æt. 33, and had been married for one year. She had consulted him for pain and occasional attacks of metrorrhagia. On examination the adnexa were found enlarged, and oöphorectomy was advised. At the operation extensive adhesions were found, and the right ovary and tube were embedded in exudation, rendering the operation somewhat difficult and tedious. On exposure of the broad ligaments, some few small yellow granules, about the size of millet seeds, were seen, which raised the suspicion of tubercle. There were none elsewhere on the peritoneum or bowel. The left Fallopian tube, which was thickened and enlarged, was removed. The tubes were resected from the uterus. [Sections of the tubes were shown. The pathological report on the specimen was as follows:—"The tubes and ovaries have been examined microscopically. Both tubes show the presence of tubercle in their mucosa; the plicæ are infiltrated with round cells, and distinct foci of tubercle containing giant cells, are seen in the swollen infiltrated folds. The thickened fibro-muscular walls show no evidence of tubercle, the disease being confined to the mucosa. The right ovary is œdematous; it shows no sign of tuberculous disease. It contains no healthy follicles, but presents some hæmorrhagic areas and degenerate lutein tissue, and a few corpora albicantia." This appeared to be undoubtedly a case of primary tuberculosis of the Fallopian tube. There was no evidence of tubercle elsewhere, as the patient was otherwise quite healthy. All recent statistics show that tuberculosis of the female genitalia was more common than generally believed. It would seem that the Fallopian tubes were more frequently affected than the other portions of the female genitalia. The occurrence also of tuberculosis of the genitalia following its presence in the lung, the localisation of tuberculosis on the site of the placental attachment, and its transmission from mother to fœtus, showed its transmissibility through the blood, and Murphy, of Chicago, who had written at length on the subject, accounts for the greater frequency of the Fallopian infection through the lower power of resistance of the Fallopian tube. The point of interest in this case was the complete absence of any infection of the ovaries.

The **President** thought the specimen a very interesting one, and that Dr. Macnaughton-Jones had raised a very interesting question. He would be glad to hear from anyone who had made any experiments in that direction.

Dr. **Inglis Parsons** asked whether all the lesions were miliary tubercles, or were any of them caseating? According to Behring, the miliary tubercle was the expression of immunisation, and the serum which he proposed to use would produce ordinary miliary tuberculosis, non-caseating tubercle, and acted by immunising the individual against the attack of the bacillus. He had met with two cases of extensive tuberculosis of the peritoneum and intestines in the last two years, where the whole peritoneum was studded with miliary tubercle. The intestines and omentum were all matted together, the mass forming the tumour, the uterus and tubes being comparatively free. After washing out the peritoneum in the worst case, the patient made a rapid recovery, and since then had increased in weight. When opening the abdomen, if one found it studded with tubercle, of a miliary character, the prognosis was good; in fact, the patient was probably undergoing a natural process of immunisation, whereas if there were caseating masses the prognosis would be bad.

Dr. **Bedford Fenwick** thought the case a very important one, and it would be well to elucidate one or two practical points. He concluded from the description that the adnexa were embedded in the ordinary inflammatory deposit in the pelvis, and there must have been a considerable amount of active inflammatory mischief about the ovaries; while the miliary deposit was on the Fallopian tubes. He had found in some cases a considerable tuberculous deposit on the Fallopian tubes, but always associated with more advanced disease of the ovaries themselves. It would be corroborative evidence in this case if an evening rise of temperature had been noted. He would also like to know what happened to the patient after the operation, whether the extraordinary tension of the abdomen disappeared? Also it would be interesting to know whether there was any ascites present? In almost every case of tuberculous peritonitis ascites was present, and it was interesting that there was none in this.

Mr. **Furneaux Jordan** said in his experience the majority of subjects of tuberculous disease were single women. As to the method of infection, he believed that it was through the blood.

Dr. **Macnaughton-Jones** in reply, said that he had no report as to the presence of any caseous degeneration in the tube. The few granules which were on the broad ligaments were the result of infection from the ostia of the tubes. In the other cases of primary tuberculosis to which he had referred, the patients were married. Ascites was not common in tuberculosis limited to the uterus and adnexa, whereas it was in malignant conditions it was common. The case, as he had said, was clearly one of primary tuberculosis of the tubes. He would like to add that primary tuberculosis of the ovary was so rare that, as Murphy said, "for practical purposes it need not be taken into account."

Dr. **Bedford Fenwick** read a paper, entitled

FOUR YEARS' HOSPITAL ABDOMINAL SURGERY,

which will be found on page 423 *et seq.*

The **President** said the author deserved the congratulations of the Society for his successful series of cases. The cases had been dealt with by the best methods of surgery at the present day. There was considerable doubt some years ago with regard to the performance of hysterectomy for fibroids. But all would agree that when the tumour filled the pelvis it should be removed, because it was certainly much better than leaving the patient alone, and the results of hysterectomy were much improved. He had known several instances of patients with fibroids who refused operation. One of them he had now watched for many years. About fifteen years ago he recommended her to have an operation done. At that time there was a case published in which an operation had been performed, but the patient died, and that decided the patient against operation. Since that time he had urged interference again and again but without success. The patient had been an invalid during all those years and confined to bed many days in the week. Her health was poor at the present time. In the early stage, when the fibroid was small and produced no bad effect, there seemed to be little reason for operation, except that the procedure could then be more easily carried out, and might have been removed by the vagina. He presumed that all the cases quoted had been operated on by the abdominal route, but when the tumour was small, the vaginal operation was often successful. With regard to the effect of the menopause in such cases, he agreed that it did not affect fibroid tumours to any extent. That day he saw a patient, æt. about 40, with a fibroid, who wanted to know if it would disappear in any way except by operation. The menopause occurred five years ago, and the tumour had been growing ever since. In this case operation was the proper course. The questions of washing out and draining were important. At one time he washed out and drained in nearly every case, but he now rarely adopted drainage except by the vagina. With regard to anæsthetics, for many years he preferred chloroform in abdominal surgery, and saw no reason for changing. He had seen some cases die after ether had been administered. However, the kind of anæsthetic to be given was very much a matter of predilection. He agreed with what had been said about the feeding of the patient afterwards. For the first twenty-four hours after the operation he never gave anything, except perhaps a teaspoonful of hot water, which sometimes relieved the great thirst from which they suffered. He commenced with milk, and often gave some weak tea afterwards. It was gratifying to hear such good results, and he trusted other Fellows would emulate the author's success.

Mr. **Furneaux Jordan** said the congratulations of everybody would be heartily given to the reader of the paper, both for the work done, for the excellent results, and also for the very interesting view which he had given Fellows of his work. There was so much in the paper with which he found himself in hearty agreement, that his remarks would be based not so much upon criticism as expression of approval. It seemed to him a mystery why patients who had fibroids were advised that if they would only wait long enough they would recover without operation. One of the leading obstetrical physicians of the country had a patient, æt. 47, under treatment for many years, with a fibroid reaching above the umbilicus. About a year ago the patient became blanched, and almost pulseless; she could not sit up in bed and had not been able to for some weeks owing to hæmorrhage. The physician repeatedly told her she was going to get better without operation. This patient consulted him, and he kept her into the hospital for some time and then did a supravaginal hysterectomy, from which she recovered. Although the physician in question did hysterectomies himself, and did them very well, the case impressed him so much that he sent another case of a similar kind, upon which also he operated, and that patient likewise made a good recovery. He had only had one death in over fifty cases of abdominal hysterectomy for fibroids. This case was operated on at some distance, and probably died from sepsis. He was quite sure his mortality of 2 per cent. was much less than would be the case if the patients were allowed to go about without operation. Then one should think of the amount of misery and suffering which such patients underwent, and in the face of that and the statistics of operation it was a mystery to him why any man in the profession should recommend a patient to avoid operation. Personally he was inclined to believe that any and every fibroid should be operated upon and removed, on account of the greater safety to the patient. The chief point which had struck him, after many years' hospital work in connection with diseases of the appendages, was the appalling condition found and the amount of disease resulting from the morbidity of midwifery. Very many doctors were always boasting that they had never had a death after confinement and never lost a patient from puerperal fever, but he only wished some of them would come to the operating-rooms of women's hospitals in the country, and he was sure they would see much which would enlighten them on the matter; they would see a startling number of pus tubes, adherent appendages, and adherent retroverted uteri which undoubtedly followed upon puerperal fever of a mild type. Operating gynæcologists saw an enormous number of such cases, and apparently it was the same in Soho Hospital, as there were 121 so affected out of 185. All the cases were not puerperal, but a large number of them undoubtedly were. It was taught everyday that midwifery must be as aseptic as abdominal surgery, and one could only hope that some day it would be so. With regard to after-treatment, he agreed with what was said about washing out and drainage. The only occasions upon which he washed out were when the abdomen was full of blood, and then it was chiefly with the view of leaving hot water in the abdomen. He practically never drained unless it were a broad ligament case. The adoption of the Trendelenberg position was a great advantage in operating on diseased appendages and often obviated flushing. If that position were resorted to as a routine procedure it would be found to afford great help in every case. He scarcely ever opened the abdomen without putting the patient into that position. He remembered that some years ago he advocated very strongly the adoption of the vaginal route in operations for pyosalpinx, even now, in the case of a big pyosalpinx which filled up the pelvis he would open and drain through the vagina, but in cases where the adhesions were above, if the degree was only moderate and both sides were affected, the advantages obtained from the Trendelenberg position were such that he would now open the abdomen and remove the appendages. With regard to after-treatment, he also abstained from giving anything to the patient for the first twenty-four hours, except a drachm or so of hot water. He thought the patients should not be allowed to suffer from the intolerable thirst which followed operation. He was in the habit of allowing a cup of tea, unless there was a tendency to sickness. These results in the main were due to perfect cleanliness, and as long as the operator observed perfect cleanliness in every detail, no matter how small, the patients would do well. If there were any fault in technique, the operator and his patients suffered for it. Again he desired to congratulate the reader of the paper upon the excellent results.

Dr. **Inglis Parsons** desired to say a word upon the subject of the menopause. It seemed almost incredible that the whole profession up to the present day should have been mistaken in their view that fibroid tumours did atrophy to a certain extent after the menopause. No one, so far, had brought forward any statistics to show that they did not atrophy. He had seen cases which did not atrophy after the menopause, but at the same time it was too dogmatic to say that none of such tumours atrophied. With regard to technique, he agreed with most of the points brought forward. He had not used a drainage tube for three years, and washing out was a practice which he seldom resorted to. He also followed the practice of pouring a pint of hot fluid into the abdomen after a long and difficult case, when the pulse was getting low, and found good results follow the administration of a nutrient enema twelve hours after operation, but nothing by the mouth for twenty-four hours. He had done 100 abdominal sections without a death, including all kinds of cases, and believed nutrient enemata had probably tided them over shock. He wished for information as to how the abdominal wall was closed; the sutures used; and whether stitch abscesses occurred. In one case, a woman with an abdominal wall nearly six inches thick, on whom he did a hysterectomy, went out of hospital apparently well; she afterwards had acute abdominal pain, and was sent back to the hospital by the doctor with the idea that her intestine had become adherent to the uterine stump. He took her into the hospital again, and after a time, as she began to get worse, he decided to reopen the abdomen. The abdomen had been sewn up in three layers—peritoneum and aponeurosis with silkworm gut, and the skin above with silk. There was no protrusion, but when he cut down he found that the aponeurosis was intact, but the intestine had pushed its way into the subperitoneal fat, and had become adherent to the under-side of the aponeurosis, causing partial obstruction. He separated the adhesion and sewed up the aponeurosis, muscle, subperitoneal fat, and peritoneum with one layer of silkworm gut, but had great difficulty in getting them together, because of the enormous thickness and the tension which resulted. Since that time, the patient remained well, but occasionally had some slight pain in the site of the scar.

Dr. **Heywood Smith** said the most important and valuable points in the paper were those bearing upon the after-treatment of cases. He desired to emphasise what the author had said about calomel. He regarded that drug as invaluable in treatment. In threatening peritonitis, 10 grains of calomel was not too much to give; it acted like a charm, and in no case did it seem to have any deleterious effects. With regard to the abstention from food immediately after the operation, he endorsed all that had been said, but would even go further, and say that where the patient was robust and well-nourished she could very well be kept without food for forty-eight hours after the operation. He doubted whether the method of giving a nutrient enema in twelve hours as a matter of routine was wise. He thought that if an enema was given it should be of water, for the purpose of stopping the thirst. If there should be any tendency to hæmorrhage afterwards, he believed a nutrient enema would have the effect of aiding the hæmorrhage rather than checking it.

Dr. **Richard Smith** said he regarded the reading of papers such as the one to which they had just listened was one of the best means of breaking down the prejudice against operating upon fibrous tumours, and would also serve as an educative influence for many. He congratulated the author on the work he had done, and he had seen a fair amount of it. A few years ago the presence of a fibroid tumour in the pelvis was considered a reason why it should not be removed, though if it were likely to be an easy operation removal might be attempted. But recent knowledge had shown that some of the most successful cases were those of tumour in the pelvis, and that it was those which showed the least danger. That was one marked step forward, as also was decision as to when the operation ought to be done. It would not be likely that in this Society, for a quarter of a century at least, there would be any creed to the effect that all tumours should be removed, but gradually the profession was gaining wisdom on the point. With regard to fibrous tumours mentioned, he would have been glad to know how many of them were myomectomies as distinguished from the removal of the whole of the uterus? It raised the question whether it was always wiser to remove a tumour by myomectomy or to remove the whole uterus? One doctor told him not long ago that he knew of a case where a tumour had been removed by myomectomy, and very alarming symptoms arose at a confinement which happened one a half years afterwards. Then there were those cases of fibroids of the uterus where there was sloughing, and which were dealt with up to a few years ago by the ecraseur. He thought the profession was much wiser now, and the practice was to operate by the abdomen and deal with them directly with strict asepsis. One knew what the method of treatment was twenty years ago when cases of septicæmia were met with, and were dealt with by dilatation and sometimes by incising the cervix freely and giving ergot. That had fortunately become a thing of the past. He thought that if their friends in the profession would read all those matters and study them they would see that in the work of removing fibroids and other work of the kind the Society had done some really good solid work. With regard to washing out, he agreed with the author. He had often seen gynæcologists, after removing a suppurating tube, with pus in the pelvis, flush out with water, and thought how much wiser it would have been to put in a swab of antiseptic gauze and trust to gentle sponging rather than washing out.

Mr. **Ryall**, while congratulating the author, said the results were to be envied by those who had to perform urgency operations, and possibly the absence of such cases accounted for the low death-rate. He would be interested to hear further details about a case which had been narrated. That was where post-operative, or almost immediate, rupture of the abdominal wound occurred. In his own experience he had two of those cases. One was many years ago, in a comparatively young girl, who was operated upon for a single large myoma. A few days after operation, however, during a fit of vomiting, the patient was seized with collapse. He had spoken to her a few minutes before, and she seemed well. He could not find any cause for the collapse, but the symptoms pointed to gastro-intestinal perforation. However, she rallied and seemed somewhat better an hour afterwards. The attack was followed by another sudden collapse, presenting the same features as one found in perforating gastric ulcer. The wound was examined after both attacks, but nothing was found to account for them. Some hours afterwards he found some fluid oozing between the skin. The wound had been closed in three layers—the peritoneum with a continuous catgut suture, the muscular or aponeurotic layer was closed with silkworm gut, and tied in three knots, and the skin by some other material. Apparently the cause of the first collapse was rupture of the peritoneum and muscular aponeurotic layer, the skin holding together for some considerable time before any peritoneal fluid exuded. The other case was a quite recent one, that of a large fat woman, who was suffering from papillomatous cysts of the ovary complicated by a myomatous uterus. Hysterectomy and oöphorectomy were performed, and after the operation she suffered greatly from distension, so much so that there was threatening intestinal obstruction. All the ordinary means were tried for the relief of her condition without success. The abdomen continued to distend, but when he arrived he found she had passed flatus. During the night she passed some more, and next morning the wound had yielded. The abdomen had been closed in the same way as the first case. He would be interested to hear how the abdomen was closed when the rupture took place afterwards. The reason why washing out had been abandoned was that it was inefficient, compared with swabbing. The best way to wash out the abdomen was by putting in saline fluid and leaving it in; and if the patient were placed in an inclined position, with pelvis raised, drainage was maintained through the stomata of the diaphragm. With regard to peritoneal drainage, he believed everyone had now given that up whenever it could possibly be avoided. There were occasions when drainage was necessary as in cases of pelvic suppuration which had extended into the false pelvis. In these results there were very few post-operative mishaps. There was nothing said as to post-operative hæmorrhage, which occasionally happens even in the best regulated hospitals. Nor was there any reference to intestinal obstruction. Another mishap was one which occurred in a case of a kind which was exceedingly rare. He removed a solid ovarian tumour from the left side, then examined the right ovary and appendix, which were apparently normal. Four days afterwards the patient had a perforation of the vermiform appendix, and a second operation was therefore necessary, from which she recovered all right. He did not think he could altogether agree as to the seriousness of the pressure exerted by a fibromyoma on the ureters.

Dr. **Jervois Aarons** said he desired only to refer to washing out. Some stated that it was a good practice, and others said it was not. An excellent paper by Dudgeon and Sargent on the question, proving conclusively that washing out, apart from the question of efficacy, was a distinctly dangerous proceeding, especially when the patient was in the Trendelenberg position. It was proved by a series of lengthy experiments that the flushing out carried micro-organisms to parts of the intestine where they previously had not reached, particularly the diaphragmatic surface generally, and advocated the procedure of mopping up and gently drying with sterilised gauze and packing off the cavity. He strongly commended the practice of leaving a hot saline solution in the abdominal cavity, as it relieved thirst.

Dr. **Bedford Fenwick**, in reply, said he was very much obliged to the various speakers for the kind way in which they had spoken of his work, which forced him to repeat that if there was credit due specially, it was very largely shared by others, and he wished they had been present to receive that approbation which had been credited to him. He had seen large fibroid tumours shrink after the menopause, and if they did not disappear certainly became much smaller. He thought they were all originally soft myomata with a considerable surface of strong muscular wall of the uterus round them, and as the uterine wall contracted he thought the tumour became atrophied. But in the hard, definitely fibroid growths, especially if sub-peritoneal and practically free from the muscular contraction of the wall of the uterus, he did not think that as a rule they shrank and disappeared. In the paper he had definitely laid it down that to justify operation the tumour should extend half-way from the pubes to the umbilicus in the middle line, or completely fill the pelvis if it was a rounded tumour, and thought that these were not the tumours which shrank or ceased to give trouble after the menopause was established. Nutrient enemata had been mentioned, and he agreed that in a certain number of cases it was an immense advantage to give them. He had had patients living for some days upon nutrient enemata alone, because of the violent sickness which could not be stopped. To give such enemata as a routine treatment twelve hours after operation was not, in his opinion, advisable, as he tried to keep the pelvis dry so as to help union and prevent bleeding from torn adhesions. If enemata were put into the rectum, the effect must be to fill the pelvic veins and thus rather tend to increase the chance of bleeding. He regretted he had not mentioned anything about sewing up the abdominal walls. He believed everyone at the hospital did it in three layers, though each had his little fads as to the material employed for the purpose. During the last two years he had used simply fine catgut for the peritoneum, very thick catgut in a continuous suture for the fascia and muscle, and fine catgut for the skin. Since that method had been adopted he did not think either his colleagues or himself had had a single case of ventral hernia. It was a matter of very great difficulty to deal with a fat abdominal wall, because one did not obtain ready union. If the amount of fat was very great one often got liquefaction, greasy fluid fat forming between the layers, which tended to tear through the skin, or to degenerate into pus. In such a case as that he had used one long mattress suture through the whole of the depth of the wall, bringing it across and tying it on the same side, so as to draw the whole depth completely together by the one mattress suture, afterwards suturing the skin one over it. Since he adopted that course he had not had any trouble with fat walls. He always gave a patient 5 grains of calomel in the evening before the operation, and considered it of great value. Since that was done there had been very much less sickness, especially bilious sickness, than previously when it was the rule to give liquorice powder and an enema in the morning. He could not say how many myomectomies he had done, but their number was comparatively few. It was only during the last year or two that myomectomies had been done instead of removing the whole uterus. He had none last year. He had considered the question of uterine pressure on the ureter, and had done many dissections with regard to it; and he is firmly convinced that the pressure exerted by a fibroid often caused kidney disease by back pressure upon the ureter; in fact, he had seen cases in which the ureter had been so dilated as to be five or six times its natural calibre, and the kidney proved to be simply a bag of urine, and a disorganised mass.

HARVEIAN SOCIETY OF LONDON.

Meeting held October 12td, 1905.

Clinical Meeting.

Dr. **Alex. Morison** showed a man suffering from mitral stenosis, upon whom paracentesis abdominis had been performed twice. The recurrence of ascites had been apparently prevented by circular strapping of the abdomen. Dr. Morison advocated this measure in preference to the more heroic ones advocated by some surgeons.

Dr. **Alex. Morison** also showed a man, æt. 46, who apparently had syphilis six years ago, and pleurisy one year ago, with progressive dyspnœa, he had displacement of the heart to the left, dulness with pulsation, and diminished breath sound over the upper part of the left chest, resonance and fair breath sounds at the left base, and marked, palpable, diastolic shot over the aortic area. The cough was brassy, but the voice was normal, and no paralysis of vocal cords was found.

The skiagram showed a dense shadow on the left side, but nothing typical. While the diagnosis suggested aneurysm of the aortic arch, Dr. Morison thought the case was one of retracted left lung with displacement and exposure of the heart.

Dr. **Maguire** considered the case was one of aortic aneurysm of the arch—and thought the left pulse was smaller than the right.

Dr. M. **Squire** showed a man, æt. 54, with possible malignant disease of the liver and gall-bladder. He had been ill nine months with pain and enlargement of the abdomen, obstructive jaundice. Liver enlarged and tender. Bile in the urine. Slight ascites.

Dr. M. **Squire** also showed a man, æt. 45, with swelling of the left leg and knee due to œdema, and pain in the knee and shin. A small rounded swelling could be felt deep down in the left iliac fossa.

Mr. **Clogg** thought the lump was probably malignant, pressing on the left iliac vein.

CONGENITAL DISLOCATION OF THE HIP.

Mr. **Jackson Clarke** showed a girl, now æt. 8, on whom he had operated by the manipulative method over two years ago for a congenital dislocation of the right hip. The child had never walked properly. Before the operation she had attended a hospital for three years and had worn a high boot. The patient was easily fatigued. When she was measured lying down, there was an inch and a quarter of shortening, and the great trochanter was the same distance above Nélaton's line. A skiagraph confirmed the diagnosis. At the present time there is no shortening, the great trochanter is in Nélaton's line. The right limb is in every respect the same as the left, and the patient walks well without becoming fatigued. A skiagraphic appearance of the right hip is normal. In other words, the patient was cured of a congenital dislocation of the hip.

Mr. **Clarke** also showed a boy, æt. 6¼, with double congenital dislocation. Both hips were gravely deformed, the trochanter being 2 ins. above Nélaton's line. The thighs could only be separated for 30′ instead of the normal 135″. Lordosis was marked, the gait was awkward and slow, and fatigue was soon felt. The patient was severely handicapped for earning a livelihood, and he was cut off from most games and exercises that gave pleasure in childhood and tended to health and strength. With increasing years his disabilities would become more and more irksome. Mr. Clarke had no doubt that he would be able to remove the disabilities permanently.

Mr. **Laming Evans**, in discussing these cases, called attention to the thickening of the soft tissues around the joint which still persisted, and attributed the limp which still remained to this thickening. He was doubtful if so good a result was possible in every case. In a large proportion the reduction had been transformed into a transposition within two years.

Mr. **Laming Evans** showed a case of "Tuberculous Disease of the Right Knee-joint," in a girl, æt. 7, which had been treated continuously for two years by a Thomas's splint with extension. There was only ¼ in. shortening, and flexion of 45′ was possible. There was apparently complete arrest of the disease.

Mr. **Daniel** drew attention to the good results obtained by Beer's method (injection of iodoform and glycerine) in these cases.

Mr. **Laming Evans** also showed a lad, æt. 17, suffering from "Spastic Paraplegia." As a result of division of the tendo-achillis in early childhood, increasing and progressive flexion at the knee-joints (from spasm of hamstring muscles) had brought about a secondary calcaneus in the feet. He suggested that in such cases this flexion at the knee-joint should be dealt with before correcting the equinus.

Mr. P. **Daniel** showed for Mr. E. B. Jones, a man, æt. 55, with a swelling over the left lower ribs in front, apparently fixed to the cartilages. There was, in addition, chronic, superficial glossitis with scars on the tongue, a scar on the penis, and some scaly deeply pigmented scars on left scapular region. Signs of early phthisis were present. Treatment with iodide of potassium was discontinued after two days on account of severe iodism. The possibility of malignant disease was considered.

Mr. **Campbell Williams** discussed the case and thought it was syphilitic, especially with the evidence of the condition of the tongue.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held October 19th, 1905.

Mr. **Priestly Smith**, F.R.C.S., President, in the Chair.

A short Presidential Address was delivered.

Dr. **Edridge-Green** read a paper on

COLOUR SYSTEMS,

and explained how his non-elemental theory was evolved, and how it differed from the elemental colour systems of other observers. He assumed that light falling on the eye, liberated the visual purple from the rods, and thus a photograph was formed. The decomposition of the visual purple stimulated the cones and set up a visual impulse; by it objects were seen monochromatically. The colour-perceiving centre was concerned with the quality of the impulse, and the colour system was developed in the following way. When few cells were present in the centre, it would only be able to differentiate between the largest and the smallest wave-lengths, the red and violet, and except for these coloured ends the spectrum appeared grey. As more and more cells were added to the centre the neutral band gradually diminished until the two colours met in the centre, then green was developed, then yellow, blue, and orange; and a few individuals were able to perceive a seventh colour. Dr. Edridge-Green then showed how inconsistent the elemental theories were with the definite facts of colour-blindness, and these were a necessary consequence of the above theory.

Mr. C. **Markus** read some notes on a peculiar

PUPIL PHENOMENON IN CASES OF PARTIAL IRIDOPLEGIA.

One of the two cases cited was that of a boy, æt. 12, and the other a woman, æt. 32. In both there was a loss of direct and consensual light reflex, together with mydriasis in one eye only, the fellow pupil was normal. In both cases, with accommodation, the affected pupil became quite small, and in the case of the woman, smaller than that of the other eye. Subsequent dilatation proceeded very slowly, and they took four or five minutes before regaining their original size. A slight contraction occurred when the lids were forcibly closed, but a touch on the cornea caused maximal contraction. Accommodation alone, caused contraction of the pupil while convergence had no effect. There was nothing to account for it in either the eye or the general condition of either patient, and the vision was normal; the boy, however, had absence of knee-jerks. A similar observation was made in the case of a medical man who was in perfect health, but one pupil was larger than the other, and did not react to light. In another patient suffering from ophthalmoplegia interna, the pupil, though inactive as a rule, contracted when the patient closed his eyelids. He explained that a break in the efferent segment of the light reflex arc would account for the mydriasis, and inactivity to light, in the first three cases; and the peculiarly slow dilatation was due to a prolonged after-effect of the stimulus. The pathological condition was discussed but left as an open question, but it was suggested that it might be an instance of abiotrophy (Gowers.)

Mr. S. **Lindsay Johnson** showed some lenses for spectacles invented by Dr. Tscherning, of Paris. Their peculiarity consisted in having one surface forming part of a sphere which had a common centre with the cornea, while the other surface was curved to suit the various dioptres, identical in power with those of the ordinary trial case. Owing to their peculiar form, all rays entering from the anterior principal point through the entrance pupil, passed through the lens in a direction nearly normal to a tangent to the surface. This resulted in a reduction of the distortion and astigmatism to an almost imperceptible quantity, except in the case of very oblique rays. Mr. Johnson also showed two photographs of squares, ruled on a large plane surface. One was taken with an ordinary lens having a diaphragm, corresponding proportionately, in size and position, to the entrance pupil of the eye; the other was taken with Dr. Tscherning's lens. The improvement in the image, the flatness of the fields, and the absence of distortion and astigmatism were most marked, and he believed that such lenses would be of great value in all cases where high definitions and rectilinearity were essential.

France:

[From our own Correspondent.]

Paris, October 15th, 1905.

Diagnosis of Tumours in the Right Hypochondrium.

The difficulties to be solved in tumours of the right iliac fossa are considerable, and sometimes quite unsuspected. Numerous organs are included in the region: Kidney, liver, gall bladder, colon, appendix—each one of these organs must be examined in turn, in order to arrive at a correct diagnosis.

Methodical research of the seat of the pain forms an important element in diagnosis. It requires considerable attention on the part of the examiner so as to determine the maximum point. It is necessary also to understand rightly the phenomenon and give it its true origin.

If, says M. Tuffier, the pain is seated over the point indicated by MacBurney, that is to say, over the appendix, it may also descend towards the pubis and become confounded with inflammation of the ovary or the uterine appendage, or when the appendix is behind the cæcum, it can follow the colon up to the costal edge, especially if there be present typhilo-colitis.

When the pain of the gall-bladder is well defined it will be found on the *external border of the rectus muscle* at the point where it is overlapped by the tenth rib. Frequently also in such cases pain is felt in the *epigastrum*, over the *scapula*, and sometimes under the right nipple. Generally speaking, the painful phenomenon of vesicular or hepatic origin observes an ascending direction towards the neck and back.

Renal pain holds a middle place between that of hepatic and appendicular origin. It is found below and more externally as regards the cystic pain; above the seat of the appendix and on a level with the umbilicus. Behind, the renal pain embraces all the lumbar region and *irradiates downwards*. It runs along the ureter towards the scrotum or labium; it is accompanied by vesicle trouble and a sort of impotence of the whole right side may be observed. Very rarely the pain ascends towards the thorax. In many cases, however, the limits of the pain are very obscure, and other symptoms must be sought for to be able to characterise the affection. These symptoms may be furnished by the *physical characters of the tumour*.

The tumefaction of appendicitis is generally badly limited; it has as basis the iliac fossa. It is fixed and has nothing in common with the dulness of the liver. These cases are easily recognised. But it must be remembered that the sub-cæcal form can present dulness situated high up, that certain appendicitis with agglutination of the intestinal loops without adherence with peritoneum. Mobile appendicitis can give the illusion of a floating kidney. The error is very grave, as the rupture of the abscess is made into the large peritoneal cavity unprotected by adherences.

Tumefactions of the kidney are generally lumbo-abdominal; they produce sometimes considerable deformity of the region; their edges are defined, their surface smooth; and while the lower border is easily felt, the upper is hidden beneath the liver.

Intermittent hydro-neprosis is the type of renal tumours. Suddenly, and without any appreciable cause, the patient is seized with violent pains in the right flank, with bilious vomiting, anuria or oliguria, tympanitis, and sometimes fainting.

Under the influence of rest or anodyne treatment, the attack disappears, ending with abundant polyuria; but it is subject to recur and without any known cause. The kidney, which had been greatly increased in volume, returns to its normal size as soon as the attack has passed. The name given to these symptoms is *renal strangulation*.

Tuberculosis, cancer of the organ, can give rise to painful phenomena, but these tumours become infected frequently, and fever is present. Sometimes examination of the blood alone can fix the surgeon on the existence or absence of suppuration.

Hepatic or perihepatic tumours possess the following characters: their dulness is continuous with the liver; *they follow the movements of the respiration*. When these two characters exist a tumour of the liver may be considered as certain. Yet frequent are the errors committed in cases of tumours and inflammation of the biliary vesicle.

The symptoms of hepatic colic are well known, but the same symptoms accompany vesicular colic with the exception of jaundice, which is absent in the latter. Locally, the tumefaction may be sometimes diffused and ill-defined; at others a rounded mass can be felt, elastic and sometimes fluctuating; in some cases it is possible to provoke a particular kind of crepitation due to the rubbing of the calculi against each other. This dropsy of the gall-bladder can attain considerable proportions, invading the iliac fossa and abdomen. These biliary tumours, when they are aseptic, and, *consequently*, apyretic, tend to diminish gradually, and finally the vesicle becomes obliterated. The diagnosis is not always easy in such cases, and it is frequently necessary to wait until the inflammation of the neighbourhood has subsided in order to arrive at a correct conclusion.

Tumours of the large intestine, and notably of the sub-hepatic angle of the colon, deserve special mention. Almost always cancerous, these tumours have not a clearly-defined clinical appearance, except in the cases where diarrhœa, alternating with constipation, bloody stools, melæna, accompany the presence of a swelling at the point where the colon lies under the liver. Frequently, however, there exist signs other than that of temporary intestinal occlusion. The cancer may take the form of a small ring, and the first manifestation of the malady is in the production of a deep abscess of the abdomen. When the tumour has attained a certain volume and has contracted adherences in the immediate region, the diagnosis is frequently very difficult. The age and general condition of the patient constitute an important factor in such obscure cases.

Germany.

[From our own Correspondent.]

Berlin, October 22nd, 1905.

At the Surgical Congress, Hr. Madelung, Strassburg, introduced the subject of

Post-operative Prolapse of Intestines.

Although the subject had been frequently written about, only a few cases had been brought forward by any one writer—not enough to generalise upon. He had, therefore, gone through the literature of the subject and collected 144 cases to which he was able to add further ones, partly his own and partly cases of his colleagues. His conclusion was that with a given tendency on the part of the patient, such an event might occur whatever might be the way the abdomen was closed after operation and in spite of every care being taken. It was most frequent after operation for disease of the internal genital organs of women, especially after incision in the middle line, but also after flank incision. It had never been seen after operation on the gall passages. The speaker had seen it after enterostomy. There was also a tendency to it after repeated laparotomies. The rupture might take place at any moment after closure of the wound, not only during the process of healing, but the cicatrices might burst. He had found 19 cases of rupture of the cicatrix from five months to twelve years after operation. Frequently, but not always, a smaller hernia preceded the prolapse, and these cases were favourable. The dehiscence did not always take place in the line of the cicatrix, but near it. With the exception of the spleen and the pancreas, all the organs could escape outside. Not unnaturally, we not unfrequently found several yards of intestine along with omentum. This lay long unchanged in the large hernial sac, incarceration rarely took place.

As regarded the cause, the suture material and the method of suturing had both been blamed. In general resorbable material seemed to favour prolapse. It was doubtful whether the method of suture was at fault, for even the most careful suturing in layers did not exclude it. Too early removal of the stitches had been held to be the cause. The opening of the bowels seemed to have no effect. A fat abdomen was rarely mentioned as a cause; very thin walls were more frequently noted. Sometimes suppuration in suture tracks was mentioned, but more frequently the recovery was aseptic. Tuberculous peritonitis was rarely mentioned. Persistent cough was given 51 times as the cause (sometimes also a few coughing attacks only). Vomiting 21 times, rarely general peritonitis. Taking all things together, we found not one single cause, but a number of causes which might well combine with a predisposition. A few causes might be guarded against, but we could not guard against a large number.

The prolapse often took place without much pain, in many cases there was a feeling of warmth that gradually extended. This was the reason why the condition might not be detected at once. Immediate reposition and closure of the abdomen was recommended, but too early interference as well as too much handling might do harm. Here it was advised to leave the prolapse outside, under the most painstaking asepsis. No bowel disturbance took place, and the prolapse gradually went back.

The course was generally favourable, the mortality small.

Hr. König (Jena) recalled to mind the time of his youth, when surgeons delighted to operate within the abdomen. Operations were often then performed, the patient discharged on the eighth day, and on the tenth the bowels came out. This was the result of the empty vanity of rapid recoveries. The abdominal cicatrix required time to become firm. The speaker had always put in a strong suture with strong material, and kept the patient on the back into the fourth week, and he had never had an abdominal hernia in his cases. The causes for prolapse were imperfect suture material (especially catgut) and faulty, superficial sutures; the sutures must go thorough the whole thickness of the abdominal wall.

Hr. Hoeftmann suggested the wearing of a sticking plaster corset.

Hr. Braun said that the causal factor was the cachexia of the patient, which prevents consolidation of the cicatrix.

Hr. Küster (Marburg) had not seen a rupture in his cases for twenty years, and he attributed his good results to his method of suture. He began with three or four silver wire sutures passed through all the layers of the abdominal wall. Then followed the suturing in stages. No suppuration occurred with the silver sutures.

Hr. Madelung, in reply, said prolapse did take place after suturing in the methods described by König and Küster. It had happened to himself. He had selected his theme to overcome the security in which many surgeons lulled themselves.

Hr. Willms related

Two Cases of Rupture of the Liver.

The first was that of a young man who was struck by a heavy piece of wood and received an internal injury. Laparotomy was performed in the upper part of the abdomen. A large quantity of blood was found, and in it, almost torn off, the left lobe of the liver. The hæmorrhage from the liver was arrested by free tamponade, compression against the vertebral column, and suture of the abdominal cavity; recovery without reaction.

The second case came under treatment twenty-four hours after a man had been crushed between two buffers. Laparotomy showed rupture of the right lobe of the liver. The hæmorrhage, which was profuse, was arrested by packing. A week after there was fever with septic infection. Death on the twelfth day. The obduction showed necrosis of the liver tissue around the tampons, which might have been caused by the tight packing. As after-treatment, large infusions of saline fluid were advisable, as even enormous losses of blood might be compensated for by them. As much as three litres might be absorbed through the large intestine.

Austria.

[From our own Correspondent.]

Vienna, October 14th, 1905.

Cysticercosis Cerebri.

At the Prague "Verein," Fischer showed a young man to the members who eight years ago suffered from contractions of a spasmodic character in the left arm. This gradually extended to the head till it finally resolved itself into a form of epilepsy, the patient becoming quite unconscious during the attack.

In 1900, Professor Maydl diagnosed cysticercus and trepanned the arm centre of the brain in the right hemisphere and removed the parasite. The epileptic attacks ceased, but the paralysis of the left arm still persisted. Seven months after the operations convulsive cramps commenced in the left arm and left side of head, especially when turning, with regular contractions of the tongue. These contractions extended to right arm and right great toe. The brain was again opened up, but nothing found to account for the disturbance. A few of the fingers remained paralysed.

Some time after this paralysis of the sensation set in on the left side, which had the appearance of hysteria and was quickly healed by suggestion.

Fischer next showed a tumour which he took from the brain of a syphilitic patient who had been heroically treated for the disease, but without any success. The operation was performed and the tumour removed, which proved to be a gumma when histologically examined.

Actinomycosis.

Zupnik presented a boy, æt. 15, who had suffered for half a year from actinomycosis on the lower part of the body. Iodine preparations of every sort had been tried without avail.

Tuberculum vetus of Koch was next resorted to, as surgical interference was impracticable. The injections were commenced with 0·0002 of a cubic centimetre at a short distance from the morbid growth, but subsequently around and into the growth. The first injection acted promptly on the temperature, but the system soon became inured to the toxine and doses of 3·5 centimetres were given without much general disturbance. In all, thirty injections were made with excellent results, the growth having been reduced to half its original size with a few tunnels through the remnant. The health of the patient improved in appearance and weight by the injections to the extent of five kilograms in body weight.

Zupnik's theory of the disease is a close alliance with the infectious diseases and depends upon a form of bacteria closely allied with that of tubercle, as the toxine of the same species acts as a powerful antidote. The streptothrix of actinomycosis must therefore belong to the same species as the tuberculous bacillus, seeing that their influence is reciprocal, although the tuberculous bacillus has not been transmitted to animals; yet by inference from their toxines the agreement seems conclusive.

He would not recommend the serum from actinomycosis to take the place of Koch's tuberculin as it would be too severe.

Operating Theatres.

NORTH-WEST LONDON HOSPITAL.

Frontal Sinusitis.—Mr. Mayo Collier operated on a case exhibiting most of the symptoms of frontal sinus disease. The patient, a woman æt. about 34, when admitted under his care had suffered for the last two years from intermittent attacks of severe pain in the right frontal region. These attacks had commenced after a severe influenzal rhinitis. During the attack of influenza the patient had suffered from a severe catarrh of the nose and naso-pharynx, which was complicated apparently by involvement of the frontal and maxillary sinuses on the right side. During the attack the patient exhibited a marked rise of temperature amounting to 103·5 deg. and tenderness and pain in both maxillary and frontal regions. The pain and tenderness, however, subsided, and for some months left no trace of its appearance. On the occasion of the second attack of influenza, some six months afterwards, intense pain with tenderness was experienced in the right frontal region. The pain was described by the patient as being most intense in character, as radiating backwards to the back of the eye and base of brain, and as being almost unbearable whilst in its acute phase. The attack was described as lasting two or three days and subsiding with the sudden appearance of considerable quantities of pus. The patient was most exact in her statement that on each occasion the pain was accompanied by swelling and redness over the right eyebrow; in all there had been some eight or ten occasions on which pain and swelling had appeared. Mr. Collier said that he had first seen the case some six months ago, when it had been brought to his notice by the gentleman who had been in attendance for some time on the patient. The doctor in many respects did not corroborate the exaggerated impression that the patient's own statement had left in Mr. Collier's mind, and affirmed that on several occasions when attacks had been complained of there had been no rise of temperature, and he was inclined to attribute some of the symptoms to the patient's imagination. On examination, however, of the nasal cavities, there was undoubtedly enlargement and thickening of the anterior end of the middle turbinal body with some distinctly inspissated pus lying on the anterior and outer aspect of this structure. The rest of the nasal cavity was slightly redder than natural, but otherwise healthy. At the first examination under cocaine, Mr. Collier endeavoured to introduce a fine probe into the frontal sinus; this was done but only apparently a very small quantity of pus exuded from the opening of the infundibulum. He therefore advised the removal of the anterior end of the middle turbinal body to afford better drainage of the frontal sinus, and as a preliminary step to open the frontal sinuses, if found requisite. At the present operation the patient was anæsthetised with chloroform, and placed in the semi-recumbent position, with a view, Mr. Collier said, of clearing up the diagnosis by exploring the anterior ethmoidal cells and the frontal sinus. With the help of the mirror and a good light he passed a large frontal sinus probe upwards and inwards into what appeared to be the frontal sinus. The instrument passed for some one and a half to two inches and distinctly encountered dead bone, this was followed by the appearance of a small quantity of thick inspissated pus. Mr. Collier said at this stage that here there was undoubtedly disease; there was caries with thick pus exuding from the neighbourhood of the infundibulum. With the history as related, it was more than probable that the frontal sinus was affected, as well as the ethmoid cells. He then proceeded to open the frontal sinus by an incision over the right eyebrow, extending to the middle line. A half-inch trephine was applied and a button of bone quickly removed. Both frontal sinuses were exposed; the right opened to a very small extent; both sinuses were perfectly healthy, and their opening apparently quite patent. The wound was carefully closed. Mr. Collier then directed his attention to the ethmoidal cells *via* the nose, and after he had opened these well up, and removed a quantity of granulation tissue and dead bone the patient was returned to bed. Mr. Collier said that this case illustrated a difficulty inseparable in the diagnosis of frontal sinus disease. The cardinal symptoms of frontal sinus disease in its earlier stages had one and all presented themselves; either the disease had been present during one or more of these attacks and had subsequently got well, or all the symptoms commonly associated with frontal sinus disease could be present and exist when the anterior ethmoidal cells were only affected. He said he had opened the frontal sinus on many occasions for the purpose of diagnosis, and, provided that a small trephine be used and care be taken that when elevating the button of bone the lining membrane be not injured, no ill result need ever be anticipated, and no disfigurement beyond the slight scar would follow.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, OCTOBER 25, 1905.

THE RE-ORGANISATION OF THE IRISH MEDICAL ASSOCIATION.

Next week the Irish Medical Association will meet in Dublin for one of the most important sessions in its history. It will be its business to lay down definitely the lines along which it means to work in the future, by deciding into what form it will re-organise its own constitution. We have endeavoured to aid its members in coming to a decision by publishing during the past six weeks a series of articles by well known members of the Association, who were selected by us not in order to support any views we have ourselves put forward.

but on account of their representative positions in the profession and the Association. If we may pass any criticism on the scope of the plans put forward by our contributors, it is that many of them have appeared to overlook the fact that the Association is not, never was, and never should be, merely a union of Poor-law officers. The question of reform in the Poor-law service is at present so important and pressing, and so much canvassed in and out of the service, that it is natural to write or speak as if it were the sole object and end of the Association. More than half the medical men in Ireland, however, are not engaged in Poor-law work, and it must be emphasised that the Association should be the Association of the entire profession in Ireland, and not merely of a minority. The duty of the Association should be the furtherance of the interests of the profession as a whole and in all its parts, and because the claims of the Poor-law medical officers are at present most pressing it does not follow that the interests of the prison doctor, of the private practitioner, and of the consultant are to be overlooked. With regard to the immediate question of re-organisation, we do not tie ourselves to any particular scheme, but we think certain requisites are essential. The scheme must be simple and easily understood, and it must be effective in making the Association its own master. Any complicated system such as that of the British Medical Association would be unsuitable to the needs of Ireland, and would be difficult to work with efficiency. It is absolutely essential, moreover, that the Association do not again delegate its executive into the hands of an irresponsible committee, but that, whatever be the mode of election of the managing body or council, it shall be directly responsible to the general body of members of the Association. For ourselves, we think the scheme embodied in what is known as the "majority report" covers these points sufficiently, and we are glad to find that its principles are receiving very general support throughout the country. If some such scheme be adopted at the meeting next week, we believe the utility of the Association will be increased manifold. If, on the other hand, any scheme succeed which will perpetuate the management of the Association by an irresponsible clique, the days of the Association as regards work for the profession may be considered as numbered. We do not wish to enter on any detailed discussion of the views of our contributors, but with one suggestion which Dr. Craig has thown out we must express complete disagreement, and that is when he suggests the multiplication of Irish Medical Journals by the introduction of a paper upon the lines of one of the existing weekly medical journals. There are at least two insuperable objections to such a scheme. In the first place, to provide a valuable journal would completely cripple the funds of the Association, and leave but a small remainder, if any, to devote to other purposes. In the second place, no matter how patriotic we may be, and no matter how much and how rightly we may desire to build up a solid and lasting structure on Irish work alone, the fact remains that, if medical science is to advance, an exchange of ideas is necessary and, that, in other words, it is fundamental that the works and writings of Irishmen should be brought to the notice of the world outside Ireland, and the works and writings of that world to the notice of Irishmen. The smaller a country is and the more anxious it is to advance itself, the more necessary is it that so far as its science is concerned it should be cosmopolitan. To cripple our mental constitution by insisting upon a pabulum limited as to those proximate principles which the universality of science necessitates is a thankless and unworthy task, but, it is what would happen, if medical men in Ireland were called upon to subscribe for patriotic reasons to a journal which want of funds would render incomplete. Nor do we think such a journal necessary. Is it not pure waste—waste of money and waste of material—to endeavour to establish one on the lines proposed by Dr. Craig, when a better is available at a small part of the cost? Why start to lay down new foundations, which may not be stable, and thereon raise a house, when there is a house all ready for occupation? At the risk of being accused of repetition, we repeat an offer made more than once to the Association. The Medical Press and Circular is prepared to hand over the editing and control of its Supplement to a properly constituted Editorial Committee, such as that suggested by Dr. Craig. It is prepared to print in the body of the Journal itself all matter, within reasonable limits, which that Committee marks for publication. It would include in its pages as much Irish matter as is of interest and value, while it would add to its Irish contributions, the best of the medical literature of Great Britain, of foreign countries, and the important medical news of the world. Lastly, with the help of the Association it would endeavour to provide a journal cosmopolitan in its character, but insular in its devotion to the interests of the medical profession in Ireland. In all things mundane there are financial relations, and not in Ireland less than elsewhere. They are important, and need careful consideration, but above all they are matters for mutual arrangement. What would be the cost to the Associaton of the proposal we make cannot be stated on the moment; but one thing we can state: should the Association desire a journal on the lines proposed by Dr. Craig, we are prepared to supply it at what would be but a small portion of the cost entailed by the establishment *de novo* of a similar journal by the Association and we are prepared to hand over to the Association the complete editorial responsibility and control of a weekly supplement. To those who say that The Medical Press is not exclusively an Irish journal our answer is clear. For nearly three-quarters of a century it has spent and continues to spend a larger sum in Ireland (with which it has a much more extensive connection) than any other medical journal; it, moreover, possesses connections in other countries which ensure the success a journal with solely Irish connections will necessarily lack.

LOCAL AUTHORITIES AND ENTERIC FEVER

The progress of public health in the United Kingdom, judged as a whole, has been most satisfactory. If we turn to particular phases and incidents, however, we are apt to find much that is calculated to disturb our equanimity. As with an advancing tide, although it is impossible to estimate the increment of successive waves, it is nevertheless easy enough to determine their general direction. On approaching this subject the inequality of standards becomes at once strikingly apparent. There is a vast gulf between the level of sanitary aims and of sanitary accomplishment that marks the local authorities of a large progressive town and of a sparsely inhabited rural district. The one differs from the other as widely as a modern ironclad departs from the model of its early progenitors, the Roman trireme and the Viking warship. As a matter of fact, the public is being constantly reminded of the vital importance of sanitation by the disasters that from time to time overtake districts that are neglectful of the prime essentials of cleanliness. One of the most recent examples was the outbreak of enteric fever at Lincoln, due to the pollution of a stream above the intake of the water-supply of the town. For twenty years the sanitary authorities had been warned of the danger by their own medical officer of health and by the Local Govenment Board. During a similar period typhoid fever had been endemic and often epidemic. Nothing was done to substitute a pure supply until Nemesis came in the shape of a disastrous outbreak of typhoid fever. The ancient city in question has sustained a shock to its prosperity and reputation that will be felt for many a year to come. What has happened to Lincoln might readily be repeated in London. The great part of the drinking water of the Metropolis is taken from the Thames, which is extensively polluted with sewage. The sand filtration to which it is subjected before delivery to consumers is admittedly a rough process which does not effectually prevent the passage of micro-organisms. The presence of persons suffering from cholera, enteric fever, and other water-borne diseases in the Thames Valley above the intakes would therefore menace the safety of nearly all consumers of London water. There is no loophole in this chain of reasoning. If Londoners are to go on drinking Thames water the only hope of reasonable safety is to insist upon the absolute sterilisation of every drop of it by some mechanical process applied before distribution. Considerable attention has of late been directed by inventors towards the production of an apparatus capable of sterilising large quantities of water by heat. While wealthy London is in this parlous condition it seems somewhat inconsistent to blame small non-wealthy provincial authorities for their faults of omission and commission as regards their water-supply. Basingstoke, however, seems to have dropped a whole century behind the times, so that even the Londoner who complacently pays for sewage-diluted drinking-water may cast his stone at the little town with the "wild, mysterious name." It seems hardly credible that for years the local supply has been obtained from a well "situated in a crowded and low-lying part of the town." So notoriously bad has been the water from that source that the Town Council has dug another well outside the town, but the old well is still used. A month ago a disastrous epidemic broke out, and the townsfolk were advised to boil all water and milk, although analysis showed the water to be just as good as formerly. It is now stated that the old well has been contaminated by the overflow from an adjacent sewer. The usual Local Government Board Inquiry will doubtless be held. The local authorities will be mildly censured and the water-supply will probably in the long run be placed on a more satisfactory footing. It is to be hoped that the Board will not be called upon one day to hold an Inquiry into a huge outbreak of water-borne disease in London. Would it not be more to the point if the Local Government Board acted more and inquired less ? Prevention is better than cure. For many years the Local Government Board was in full possession of the facts at Lincoln. Why did they not insist upon the provision of a pure water-supply for that town. If the Board have not known of the bad supply at Basingstoke, why have they not known ? If the Board knew, why has so disgraceful a blot upon our national sanitation been allowed to continue for a single day ? What have the Local Government Board to say about the Thames as a source of the drinking-water supply of London ? If this Government department is to deserve the futher confidence of the nation it will only be by the adoption of a policy of prevention administered with firmness, upon an ascertained basis of facts.

Notes on Current Topics.

Infant Mortality in Dublin.

The subject of infantile mortality chosen by Dr. W. J. Thompson for his inaugural address at Jervis Street Hospital, Dublin, is one of incalculable importance to the public at large. It is moreover one suitable to an occasion when it is customary to augment the usual hospital audience by an influx of lay visitors, since it is a subject on which a medical man can speak with most authority, but which is really a matter for the layman to consider. It is well too, to impress on medical students the importance of the subject at the very outset of their career. The condition of affairs in Dublin is indeed serious enough to attract the attention of all concerned in the welfare of its citizens. Though no worse than the average English city of its size, yet it shows a rate of 160 deaths during the first year of life per 1,000 children born. Much of this mortality is avoidable, and with proper housing for the poor and education of the mothers in the matter of child-rearing, there would doubtless be a great improvement. Dr. Thompson is an ardent admirer apparently of the "*gouttes des laits*" institutions of the Continent, and he advocates the establishment of a milk depot for infants in Dublin. A matter like this is not to be settled off-hand, and there are many careful observers on the Continent who have found it necessary to point out how easily such a system may be abused. It is, we believe, essential, unless a mother be prevented by serious debility or by absolute necessity of working, to insist that she should herself nurse her child. A milk depot renders it easy for a mother to shift her responsibility in this direction, in many cases without knowing the wrong she is inflicting on her child. It may be admitted that in Dublin the danger from this cause would not be as great as in many other cities owing to the conservatism of the Irish people, but it is one that should not be overlooked.

Faith-healing at the Church Congress.

At the recent Church Congress at Weymouth there was a discussion on the subject of "Faith-healing," and it is with real pleasure that we note that, on the whole, a moderate and common-sense tone pervaded the discussion. We have been accustomed in the past to so much ill-considered enthusiasm and superstition among clerical folk with regard to "Christian Science" and cognate practices, that it is a relief to see that a more rational and critical attitude is being assumed. The opener of the discussion remarked that Christian Science was not to be ignored or treated as the creed of fools, but that it was merely an exaggeration of the well-known principle of bringing the mind to aid in the cure of the body, and that this principle of cure by suggestion was widely practised in other circles. The Christian Scientists went to extreme lengths, and should be opposed not by denunciation, but by unwearied teaching of the old faith. A comic element was introduced by the next speaker, who mentioned that he had seen people healed by faith in America, but that the cure was combined with the anointing of oil, and as the oil was petroleum, and petroleum had healing properties, the element of faith was supplemented by physical means. The Bishop of Salisbury speaking later, on the visitation of the sick, said that if they adhered to the teaching of the Bible they need not worry themselves much about Christian Science, and that "he had no doubt that one reason why that strange form of doctrine had a vogue in certain quarters was because they had not sufficiently recognised that it was part of the visitation of the sick to pray definitely for the sick man's recovery." Temperate, sensible utterances such as these are what ought to be expected from the leaders of religious thought, and it is refreshing to hear them after the wild nonsense that so frequently is brought to our notice as having emanated from educated clergymen.

Professor Clifford Allbutt on Medical Education.

Any utterance of Professor Clifford Allbutt is listened to with respectful attention by the medical profession, for there is no teacher who brings to his task a higher sense of duty and a more philosophical view of facts. His recent speech at the opening of the medical session at King's Hospital stands out above the somewhat wearisome level of "opening" addresses for its intrinsic interest, as well as for its importance in coming from such a source. Having laid down his views as to the best training for a physician—a training in principles at a university and an instruction in facts and technique at a hospital, Dr. Allbutt is compelled to admit its impracticability for the average man, since he cannot afford to spend such a slice of his life in preparing for his life-work. Five years is in the opinion of many a disproportionately long period to spend in a technical training, and in the opinion of all, except a few enthusiastic teachers unable to see beyond the benches of their own lecture rooms, this five years' course is already over-crowded. Unfortunately no one, not even Dr. Clifford Allbutt, sees a way out of the difficulty, and all that can be done is to point out the evils of further development along the present lines. Dr. Allbutt is an ardent advocate of the "one-portal system," as a corollary to the adoption of which would be the cessation of competition between university and technical school by the devotion of each to its proper business. The technical school, or hospital, would prepare for the State Examination, while the university would give an education in the broader sense to those with time and means to afford it.

A Cause of Infant Mortality.

From a summary of an address given by Sir William Church to the York Medical Society, we learn that in Sir William's view there is undoubtedly a connection between compulsory education and infant mortality. According to the ex-President of the College of Physicians, although compulsory education has been of inestimable benefit on the whole, before school boards and attendance officers came on the scene, the elder girls of a working-class household had a "thorough training by their mothers in the management of their homes and in the care of young children," whereas now, through having to go to school till fourteen years of age and to work afterwards, they marry and set up house without knowing how to make a home comfortable, how to prepare food, or how to look after a baby. But is there any evidence of difference in infant mortality among children living under similar conditions before and after 1870? The girls of working-class parents, in our experience are pretty freely utilised by their mothers in the economy of their house-holds, and they learn all that the mother has to teach them before a girl of gentle breeding knows the price of a pound of sugar or what the staple diet of a baby consists in. The fault lies in the mothers' own ignorance of domestic economy and infant management, and there is every reason why these important subjects should be taught to girls in elementary schools between the ages of twelve and fourteen, even though they have to sacrifice lessons in French and advanced arithmetic. It is not compulsory education *per se* that is at fault, but the misapplication of the subjects taught to the children's probable future. We welcome heartily, however, Sir William Church's condemnation of the practice of sending children to school at the age of three. His assertion that teaching at such ages has a benumbing effect on the mental activity will meet with endorsement from all experienced medical men.

Thrombosis in the Corpora Cavernosa.

MANY medical men have from time to time found themselves completely baffled in the treatment of certain cases of persistent priapism. Of course, in many cases this symptom is one of the results of some cerebro-spinal lesion, and local treatment can have no effect. In other cases, however, the priapism is distinctly painful, and unaccompanied by sexual desire, and is due, not to any nervous impulse affecting the male organ as a whole, but to some local condition which causes engorgement of the corpora cavernosa, while the corpus spongiosum remains flaccid. Where the exciting cause is some inflammatory condition of the neck of the bladder or the prostate or other part in the neighbourhood, local treatment usually gives, if not complete relief, at any rate alleviation of a distressing symptom. Sometimes, however, all local treatment, such as warmth, cold, bleeding, and general treatment by the administration of sedatives have alike failed, and the pathology of the condition has been an enigma to the medical attendant. Such cases have recently been operated on by Mori, Rose, and other surgeons, with the result that it has been found that the real condition is one of thrombosis of the blood in the corpora cavernosa. Why the blood in the corpora cavernosa should be specially subject to clotting is not clear, but the practical point stands out that a complete cure can be effected by incising the penis, and completely expressing the contained clots. This should be done as early as the diagnosis is made, as in long-standing cases the tissues of the penis may be so altered as to render erection impossible in the future.

Sir Thomas Browne's Tercentenary.

IN the celebration of the tercentenary of Sir Thomas Browne's birth the City of Norwich has been doing honour to an interesting character, whose reputation has certainly not suffered by the neglect of posterity. Sir Thomas Browne's books, especially the "Religio Medici" and the treatise on Urn Burial, have received warm commendation and respect at the hands of scholars and critics of many schools, and the author has come to be regarded almost as a patron saint by the medical profession. There is evidence that he was a respected and influential citizen in the town of his selection, and certainly he enjoyed the friendship of men like Bishop Hall and Whitefoot, whose friendship was worth having. But it is difficult to enter into the motives that dictated all his sayings and acts, and it is at least charitable to suppose that he cast away some of his youthful follies. The inconsistencies of a man writing that he wished men procreated like trees, and that woman was only the rib or crooked part of man, and yet marrying and procreating twelve children, was as apparent to the wits of his time as it is to students of to-day. Other facts that it is difficult to comprehend are—how the author of "Pseudoxia Epidemica" could have retained his early belief in witchcraft, and, still more so, how a man of scientific training could have rejected Galileo's work as ridiculous, and this for the feeblest of reasons. Perhaps, however, the incident in Sir Thomas Browne's career that it is least easy to reconcile with the highest equalities is his acceptance of a knighthood at the unworthy hands of Charles II. after that doubtful honour had been refused by the Mayor of Norwich. Probably the simplest explanation of these puzzling occurrences lies in the fact that though Browne could be playful he was unblest with a sense of humour, and without humour we are apt at times to make ourselves a laughing-stock to our fellows.

The Plague Outbreak at Leith.

THE outbreak of plague which occurred at Leith in June of the present year offers an instructive contrast to the Glasgow outbreak of five years ago. In Glasgow, at least one death had occurred, and several patients were suffering, before the nature of the disease was suspected; consequently it took much time and trouble to eradicate the infection. In Leith, the disease was recognised in the first patient under observation, and in consequence the outbreak was easily controlled. In Glasgow, too, the disease occurred in a densely crowded insanitary area, whereas in Leith the family affected lived in an airy and clean workman's dwelling, and the people of the neighbourhood exerted themselves to the utmost to aid the sanitary measures of the public health authorities. Dr. Robertson, the Medical Officer of Health for Leith, contributes to the current number of the *Edinburgh Medical Journal* an interesting account of the origin and history of the outbreak. The persons affected all belonged to one family—a man, a Corporation labourer, his wife, a rag-picker, and two children, a boy and a girl. Only one death occurred, that of the father. In the boy a bubo occurred in the neck, but in the other patients typical buboes were in the groin. No source of infection was definitely traced, but it was believed that the organisms had reached Leith in the rags, in picking which the woman was employed. Extensive examination of rats in the neighbourhood failed to detect any infection with plague.

Domestic Animals and Disease.

Lovers of domestic animals are hardly as a rule sufficiently cognisant of the fact that their favourites are liable to suffer from various diseases communicable to man. Medical men, too, are likely enough to overlook domestic animals as a possible source of infection in various contagious diseases. The diphtheria of cage birds, for instance, though not always a specific disease, is in some cases at least due to the presence of the Kleb-Löffler bacillus, while in others it is started by the colon bacillus. Whichever be the infecting organism it may give rise to a similar process in the human throat. It is of course well known that mange and ringworm may be transmitted from the dog or cat to the human subject. It has been long known that the dog acts as a host for the tænia echinococcus, whose eggs in man give rise to hydatid cysts, and it has recently been shown by Dévé that hydatid cysts occur most commonly among people who are in constant contact with dogs. While there is still doubt as to the identity of the tuberculosis of men and of animals, there can be no question that cats may be infected with human tuberculosis and may thereafter return the infection to man. The transmissibility of rabies from cats and dogs to men is so well known as hardly to need mention.

The Chair of Midwifery in Edinburgh University.

The Curators of Edinburgh University met last week for the purpose of electing a successor to Professor Simpson in the Chair of Midwifery, and appointed Sir Halliday Croom. Their selection was not unexpected, and indeed, as we understand, was a matter of unanimity. Sir Halliday Croom is one of the best-known of British obstetricians, and is in every way most suitable for the post. We offer to him our congratulations on a well-deserved success and to the University similar congratulations on having obtained so distinguished a successor to fill a post vacated by his eminent predecessor. Deeply as no doubt the departure of Professor Simpson will be felt, it will be a matter of congratulation to all concerned that his post has fallen into such capable hands. At the same time the Curators must have had a certain difficulty in making their decision, as several candidates of the first rank presented themselves. The new Professor is connected with the University from his graduation. After that event he spent some time in study in Paris, and on returning to Edinburgh was appointed an assistant to the Professor of Medicine. When Professor Simpson was elected to the Chair of Midwifery, Dr. Croom became his assistant, and for seven years conducted large tutorial classes in midwifery and gynæcology. Later he resigned this appointment, and taught in the extra-mural school. He has held the post of Physician to the Royal Maternity Hospital for twenty years, and is a Past President of the Royal College of Surgeons of Edinburgh. He has also been President of the Obstetrical Section of the British Medical Association, and has filled the Chair of the British Gynæcological Society. He was knighted in the year 1902. *Floreat.*

The Scarlet Fever Dairyman.

Last week a milkseller of Deptford was prosecuted at Greenwich Police Court for a particularly gross offence against the public health. It appears that on August 1st a local medical practitioner was called to the defendant, whom he certified to be suffering from scarlet fever. Next day he told defendant the disease might be something less serious, but still advised him to go into hospital. On August 2nd a sanitary inspector called and instructed the defendant's wife to discontinue the sale of milk. On August 10th another medical man found the defendant "peeling," but on September 1st the man was still carrying on the business and actually served two customers in the inspector's presence. It would be hard to imagine a more culpably gross and callous offence. The magistrate showed his sense of the seriousness of the case by inflicting a fine of £20, or one month's imprisonment. It would have been understandable had the offender been sent off to prison at once under a sharp sentence. For ridiculously petty offences regiments of persons are sent off to prison daily throughout the kingdom. Why should not the tradesman who recklessly endangers the health of the public to fill his own pockets be similarly punished? It is likely that anyone who caught scarlet fever from that dairy could recover heavy damages by civil action. That sort of thing would soon bring dairymen to realise their responsibilities to the public.

"The Wrong Bottle."

Serious or fatal results are week by week recorded in the public newspapers where poisonous stuff has been swallowed by error from "the wrong bottle." An incident of the kind took place at Plymouth. A prominent citizen, who had been for some time under medical care, missed his medicine bottle. A search was made, and ultimately a precisely similar bottle was brought to him. He took a draught, and it was then found to be some poisonous stuff used for cleaning carpets. The fault in this instance lies in the incredibly foolish practice of putting dangerous fluid of that sort into an ordinary medicine phial. From a common-sense point of view it would be advisable to make it compulsory to put up all poisonous and dangerous preparations in specially shaped poison bottles. The simple poison label, although useful, is at best an imperfect line of defence. Nowadays there can be no excuse for not using distinctive bottles. There are various cheap and excellent phials sold of unusual shape or moulding not to mention some most ingenious plans for marking the bottle with a little bell or a spiked collar, which would be recognised in the dark. The attention of Parliament might well be drawn to this small detail of administration.

Flies and the Spread of Infection.

The plague of flies of the Biblical narrative in Egypt must have taken place some thousands of years ago. It is only of late years, however, that the full significance of the fly has been grasped by the omniscient ardour of modern science. It is probably some eight or nine years ago that experiments were recorded in the pages of the Medical Press and Circular, showing that flies were able to convey definite infective material from one place to another. The method of demonstration was to induce a blue-bottle fly to walk across a pure culture of some bacillus or other, and then to extend his peregrinations across the face of a glass plate spread with a culture medium. The tracks of the infected fly were shortly afterwards outlined in broad splashes by the growth of colonies. Last week these interesting facts were rediscovered by the English newspapers, who made much of similar experiments conducted by M. Chaulemene, the well-known Paris bacteriologist. There is no doubt that flies play a considerable part in the spread of disease, notably of enteric fever. Not unnaturally, perhaps, the tendency of the pendulum is to swing too far in the other direction. It is desirable to remind certain enthusiasts that the old, well-recognised agencies for spreading enteric fever still exist, and that flies play an important part as scavengers in the scheme of Nature. Could we do without flies? Hardly. The alternative is to do away with the typhoid fever germs.

PERSONAL.

Lady Lumsden, widow of Sir Harry Lumsden, has, through Dr. Matthew Hay, medical officer of health for Aberdeen, subscribed £1,000 to start a sanatorium for consumptives. The condition is attached that if nothing should be done within the next six months her offer will be withdrawn.

Sir Frederick Treves will give an address on "The Army Medical Service," at the Royal Pavilion, Brighton, on the afternoon of the 27th inst., at the inaugural meeting of the Brighton and Sussex Medico-Chirurgical Society.

Dr. St. Aubyn-Farrer, President of the Association of Medical Diplomates of Scotland, will receive the guests, by a conversazione, at the opening of the Winter Session, to be held at 11, Chandos Street, Cavendish Square, London, W., on Tuesday, November 7th, from 9—12 p.m. Further information may be obtained from Dr. Walsh, 18a, Hanover Street, London, W., the Hon. Secretary.

At St. Luke's Church, Liverpool, the Bishop of Ripon preached a special sermon on the 15th inst., the occasion being the annual service for the members of the Liverpool medical profession.

Dr. S. H. R. Lucy, of the Federated Malay States service, becomes Colonial Surgeon Resident of Penang, and Dr. W. S. Sheppard, Superintending Colonial Surgeon, Singapore, takes over the duties of Colonial Surgeon, North Province Wellesley, Penang.

Sir John Halliday Croom has been appointed to the Chair of Midwifery in the University of Edinburgh. Sir Halliday was knighted in 1902, and was some time ago assistant to Professor Simpson, whom he has now succeeded. He is a past President of the Royal College of Surgeons, Edinburgh.

Sir Wm. Church, K.C.B., ex-President of the London Royal College of Physicians, filled the post of Orator at the annual gathering of the York Medical Society, held on the 18th inst.

At a recent meeting of the Lincoln Council, the name of Dr. F. S. Lambert, of Balgowan, Newland, was approved as City Sheriff for the ensuing year.

The opening demonstration at the Hospital for Consumption and Diseases of the Chest, Brompton, will be given by Dr. A. H. Greg on Wednesday afternoon, October 25th, at 4 p.m., the subject being "Examination of the Chest by the X-Rays."

Mr. Alderman T. B. Crosby, M.D.St.And., who stands first in rotation among the aldermanic body to serve the office of Sheriff of the City of London, will present himself for election at the next assembly of the Livery. Dr. Crosby has been a member of the Corporation for twenty-eight and an alderman for seven years.

Mr. Henry Morris, F.R.C.S.Eng., the senior surgeon of the Middlesex Hospital, has made the most generous gift of £1,000 to form the nucleus of a permanent endowment fund in benefit of the Medical School of the Middlesex Hospital.

Mr. R. Lawford Knaggs, M.A., M.D. Cantab., F.R.C.S., Surgeon to the Leeds General Infirmary, has been appointed Lecturer in Practical Surgery in the School of Medicine attached to Leeds University.

Dr. Theodore Williams, Hon. Consulting Physician in London of the St. John's House of Rest. Mentone, having resigned the post in consequence of pressure of other work, is succeeded by Dr. Leslie Thorne Thorne. It may be added for the information of such of our readers who may not be conversant with the Mentone House of Rest, that it was established twenty-five years ago to enable the clergy and other professional men of small means "under doctors' orders" to reside during the winter months on the Riviera for convalescence, or rest from overwork, at the nominal and inclusive charge of 20s. per week, the balance being made up by voluntary subscriptions. About twenty medical men in the provinces having kindly offered their services as referees, it will be no longer necessary for applicants to travel to London for examination.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

New Professor of Midwifery, University of Edinburgh.—At an adjourned meeting of the curators of patronage, held on October 16th, Sir J. Halliday Croom was unanimously elected Professor of Midwifery in room of Professor A. R. Simpson, resigned. Sir Halliday Croom is a Dumfriesshire man, the son of a clergyman of the United Presbyterian Church, and has a wide reputation throughout England and Scotland as a gynæcologist and obstetrician. He entered the medical profession thirty-four years ago, and after a period of study in Paris became an assistant in the University, first to the Professor of Practice of Physic, then to the Professor of Midwifery. In his connection with the latter chair, which lasted for seven years, he organized and conducted a system of tutorial instruction, which enabled him on resigning his University appointment, to enter the lists as an extra-mural lecturer with every prospect of success. Though his class on midwifery was never a qualifying one, the fact that it was voluntary did nothing to diminish its popularity or the numbers who attended it. For many years the attendance reached as high as 200. Sir Halliday Croom was for twenty years a physician to the Maternity Hospital and for fifteen gynæcologist to the Royal Infirmary; in both of these offices each succeeding year enhanced the esteem in which he was held by his colleagues as a clinician, and by his students as a teacher. Sir Halliday Croom obtained a gold medal for his theses, he has been examiner in the Universities of Oxford and St. Andrews, he has been President of the Royal College of Surgeons of Edinburgh, the Edinburgh Obstetrical Society, and the British Gynæcological Society. As a contributor to medical literature, he is best known as the author of "A Study of the Bladder during Parturition," besides having written many articles on gynæcological and obstetrical topics. Dr. Croom received the honour of knighthood in 1903. His appointment to the Chair of Midwifery will involve his return to two posts from which he had retired—that of Gynæcologist to the Infirmary and Physician to the Maternity Hospital.

Opening of the Glasgow University and the Medical Colleges.—On Thursday, the 19th inst., the classes at the University and Queen Margaret College commenced work for the Winter Session. There was no formal opening, but the numbers of students attending the various classes show signs of being well maintained. The election for the Lord Rectorship of the University takes place shortly. The candidates are the Marquis of Linlithgow, Conservative, and Mr. Asquith, Liberal. The students are making active preparations to make a good fight for their respective parties. The Winter Session at Anderson's College and St. Mungo's College also started on the 19th inst. An interesting address was given at the opening of Anderson's Medical School by Sir William Taylor, M.D., K.C.B., ex-Director-General of the Army Medical Service, who spoke of the advantages and disadvantages of

SERVICE IN THE ARMY AS A MEDICAL OFFICER.

There was always the certainty of making a livelihood from the commencement, and there was a pension on retirement. Another advantage was that an Army medical officer had the opportunity of seeing much of the world. Then he had the privilege of serving with the Army of the King in the country's campaigns. To realise this as a privilege it had to be experienced. However, there were also disadvantages. Sir William went on to say that one thing which seemed a disadvantage to many was that, although the Army medical officer was encouraged to keep up his professional knowledge, there were still drawbacks from this point in medical service. Then there was no chance of saving in this service, as the income was eaten up every year, and also there was no opportunity of becoming wealthy. The pension received on retirement was not much more than could keep himself, or, at least, a very small family. Another disadvantage was that a great number of years required to be spent abroad, away from home. He himself had spent 36½ out of 41 years' service abroad. Sir William Taylor was accorded a hearty vote of thanks at the close of his address.

BELFAST.

Queen's College Better Equipment Fund.—The second list of subscriptions, in response to the offer of Sir Donald Currie to give £20,000 if a similar sum were raised by the College authorities before Christmas, appeared in the local papers last Saturday. Though no large sums are to be found in the list there is a most satisfactory number of subscriptions from old students of the College, and from business men quite unconnected with it. The amounts vary from £150 down, and bring up the total of the fund to £14,161. This is still nearly £6,000 short of the desired amount, and it is to be hoped that every old student of the College will give even a little help towards making up the deficit, that Sir Donald's generous offer may be availed of to the full. Many old Queen's men hold important and lucrative posts in India and the Colonies, and copies of the President's appeal have been sent to them as far as their addresses are known. No doubt a prompt and liberal response will be forthcoming from many of them.

Correspondence.

RE-ORGANISATION OF THE IRISH MEDICAL ASSOCIATION.

To the Editor of The Medical Press and Circular.

Sir,—If I possibly can I will attend the meeting of the Irish Medical Association on the 31st instant. But, as I fear that circumstances may be too much for me, and may compel me to remain at home, and as I am deeply interested in the results likely to flow from the coming meeting, I hope you will give me space to air my opinions, so that co-workers in the I.M.A. may see them before the meeting. I have read over very carefully, and with the respect and attention due to such wise and proved leaders, the articles appearing recently from week to week by Professor Kinkead and Drs. Mahon, Leeper, Greene, and the redoubtable Marlay Blake, and through them all (expressed or not) one can feel the undercurrent of dissatisfaction and distrust of those who should be with us, some of whom have reaped benefits from the labours of the I.M.A. men—and (almost as bad) of those who though *in* our ranks, are hardly *of* us, who take little interest and no trouble. They hope *we may* win the battle *for them*,,but they never think of holding up our hands. They are just lukewarm. And, Sir, here, more than in anything faulty in our organisation, is the weakness of the I.M.A.

No matter how good a tactician a leader may be, how capable a strategist, or how just and holy his cause, on the day of battle, his success must principally depend on what he has behind him; on the courage, discipline and *esprit de corps* of the rank and file. And this has ever been the weak spot in our organisation. The recruiting has hardly been a success; volunteers have been few, and we have suffered from a low professional morale and want of cohesion. When "one for all and all for one" becomes our motto, there will be little need of discussing organisation schemes. We need, to my mind, to strengthen our foundations and build up from the general body of an enlightened profession a superstructure that will not merely look well on paper, but be a fortress of defence and a shelter strong enough to cover and protect every member of the profession suffering from wrong or threatened with injustice in Ireland. And to do so effectively every member of the profession in this country should be a member of the I.M.A., so that, concurrently with the initiation of a new scheme of a smaller but better equipped and more effective executive we should have a larger electorate to draw the executive from. I do not consider a committee of council an unmixed evil, and can foresee many circumstances in which in urgent cases it may be necessary. But I think we might do away with a *fixed* committee, and appoint a fresh committee at each meeting of council, and so do away with the danger of the "virtual triumvirate," of which Dr. Greene writes, and which every other writer hints at. As to representatives being voted for provincially or nationally I think matters little, so long as a definite number of representatives be allocated to those residing in each division of the country. I concur with Dr. Marlay Blake that re-organisation is a minor question, except in so far as it may conduce to the vitalising of the Association as it is, and the attracting of new members; and I think it is unfair to lay so much stress on the Poor-law aspect of our Association. *Every other public service* in this country has been benefited, and its interests safeguarded, and the rights of private practitioners upheld as fully as the Poor-law section. And it is merely because the conditions of that service are more galling and injustice more patent, that it makes the most noise just now. But I think that many can remember that even a President of the Royal College of Surgeons, in the person of the late surgeon, W. F. Wheeler, has been helped to victory, when fighting his own battle, and that of the profession, against the Irish Government in the famous Shaen Carter case. This may be very old history now, but history has a habit of repeating itself, and even presidents of Royal Colleges are the more powerful by being bound up in "the bundle of sticks." And, by the way, that is exactly what we require, an organisation to collect the weak and scattered "items" of our profession, and bind them up in a bundle strong enough to resist any Government attempt to break them or separate them, and so deal with component parts instead of a united whole.

From the Poor-law point of view, I concur with every writer in the Medical Press series. We require superannuation as of right, and a fair wage with definite periodical increment, and the repeal of Clause VI. The other necessary reforms will follow as the day the night.

One thing I would impress on the new Council is that we must be treated as a whole—*as a service* and not sectionally; the same treatment and conditions for Cork and Down, for Mayo and Dublin. I see the most diverse conditions as to "scales" and "increases" have been passed by guardians, approved by the Local Government Board, and ruefully accepted for better for worse by helpless Poor-law M.O.'s, leaving matters to be re-opened and again fought for in the near future.

I must deprecate the statement and insinuation that only recently the Association has done good work. It has done good work *from the beginning*, steadily up to now, and wonderful work with the poor material it had at its command. And I only hope we may secure as successor to Dr. Gick a man imbued with a like spirit, and as tactful, patient, and wise, and as helpful to any member who sought his advice. And I hope we will not suffer him to pass away from among us without a substantial recognition of his long and faithful services to us and our Association.

I remain, Sir, yours truly,
J. Wybrants Olpherts.

P. S.—There are many other aspects of the question I might have referred to, but must refrain from a greater trespass on your space.

To the Editor of The Medical Press and Circular.

Sir,—After a considerable period of excitement some of the members of this Association would seem to have settled down to think, and let us hope they will take time to do so and consider well any scheme of reform put forward before they adopt it. The present tendency would seem to be toward resignation of members, and I feel that if the principle of "provincial" as against "county" representation be decided upon, this tendency will increase. What will nine-tenths of the members in a province know of the men who will be put forward to represent them? It is not always the men who write or talk most who are the safest guides. I take it that one of our chief objects is not alone to maintain our present strength, but to increase it; and to my mind the only way in which this can be done is by keeping up a local interest in the Association by means of small area—say, county, and in a few cases a combination of counties—and school representation. It is most important to enlist the interest and sympathy of the schools, and to encourage all young men leaving them, more particularly those of them who intend to remain in this country, to become members. With these objects in view, I would suggest that the Council consists of—

1. The president for the time being.
2. A representative for each county whose membership is not less than twenty.
3. (To meet the case of counties whose membership did not amount to twenty.) A representative for two or more counties whose membership amounted to twenty or over.
4. A representative from each medical school in Ireland.

The council so constituted would meet once a quarter.

It would elect from amongst its members an advisory committee of five, resident in or near Dublin, or, say, one from each province, with the president, who would meet when summoned by the secretary as occasion might require to assist him in dealing with urgent matters and in the giving of advice to county councils when necessary. This committee not to initiate any new policy, and to be reponsible to the council.

I do not at present propose to deal with the work of the Council of the Association. Good, sound work was done by it in bygone years. The less said about recent performances the better.

I am, sir, yours truly,
H. D. A. Warnock.

Donegal, October 21st, 1905.

Obituary.

JOSEPH COLLIER, M.B.LOND., F.R.C.S.ENG.

We announce with regret the death of Mr. J. Collier, which took place unexpectedly on the 12th inst. in Manchester. Mr. Collier had already achieved a considerable reputation as a surgeon, and his death at the age of fifty interrupts a brilliant and useful career. As honorary surgeon to the Manchester Royal Infirmary and as lecturer on practical surgery at the Manchester University, he had taken an active part for many years past in the training of medical students in that part of Lancashire. Mr. Collier was born at Hyde in 1855. He was educated at the Manchester Grammar School and at Owens College, Manchester (now the Manchester University). He graduated as M.B. of the University of London in 1883. He was the University scholar, and won the gold medal in forensic medicine, besides taking honours in medicine, physiology, and histology. In the following year he took the B.S. degree, with a University scholarship, and the gold medal in surgery. He was a Fellow of the Royal College of Surgeons (England) and a Licentiate of the Apothecaries' Society. He became in turn resident surgical officer and surgical registrar at the Infirmary. On the expiration of his term of office he established a private practice, and this gradually assumed large dimensions. He acted as honorary surgeon to the Children's Hospital at Pendlebury, and visiting surgeon to the Workhouse Hospital at Crumpsall. In 1899 he returned to the Royal Infirmary as honorary assistant surgeon, and shortly afterwards he became honorary surgeon. This position he held at the time of his death. For several years past also he has been lecturer in practical surgery at the Manchester University. Mr. Collier was at various times president of the Manchester Pathological Society and vice-president and president of the Manchester Medical Society. He was an occasional contributor to the medical journals. Mr. Collier was devoted to athletics. In his youth he had been a noted football player, and in later life he became a famous mountaineer. His holidays were usually spent in Switzerland, and he has lectured in a very entertaining manner on some of his Alpine climbs. Mr. Collier was formerly a captain in the Royal Army Medical Corps Volunteers. As the captain of the Manchester Golf Club, he was present at the club's last annual dinner, and delivered a bright and witty speech.

Society of Apothecaries, London.

The following candidates, having passed the necessary examinations, received the L.S.A. Diploma of the Society during the October meetings of the Court, entitling them to practise medicine, surgery, and midwifery:—G. N. Biggs, P. L. Vawdrey, E. W. T. Watts, P. C. West, and J. M. Wilson.

Medical News.

Opening of the Winter Session at Jervis Street Hospital, Dublin.

THE Medical Session was opened on October 17th, at Jervis Street Hospital, when a paper was read by Dr. Thompson, on the subject of "Infantile Mortality." Sir Francis Cruise, D.L., presided. Dr. Thompson's address appears on pp. 426 *et seq.* At its conclusion, the Lord Mayor proposed a vote of thanks to Dr. Thompson. He said the subject was one of the most important that could be debated. He would do his best as a member of the Technical Education Committee to have the proper treatment of infants taught. Sir William Smyly seconded the resolution, and said the question of infant mortality was more important than Home Rule, Redistribution, or any of the other burning political topics. Though infant mortality was very high in Dublin, yet that of the whole country together was much lower than that of England and Wales. The subject was one which should be deeply interesting to students of medicine, and he hoped that those who were about to begin their studies would pay particular attention to it.

The Chairman, in putting the resolution, said that the great end to be accomplished was not alone to teach mothers to keep their homes healthy, but to teach them the proper modes of dietary for their children. Milk was, when pure, a perfect food, but when impure a fatal poison.

The motion was passed amidst applause, and after a cordial vote of thanks had been passed to the Chairman the proceedings terminated.

Annual Dinner of St. Vincent's Hospital.

THE annual dinner of this hospital was held on the evening of October 17th in the Shelbourne Hotel, and was largely attended by the hospital staff, past and present students, and many visitors. The chair was occupied by Mr. McArdle, F.R.C.S. After dinner, and after the health of the King had been proposed, the Chairman proposed the toast of St. Vincent's Hospital, and in the course of a somewhat lengthy speech referred to many current events of interest. In particular he drew attention to a recent pronouncement by the President of the Queen's College, Cork, in which the latter gentleman seemed to cast a most undeserved slight on the fairness of the examinations conducted at the Royal University of Ireland. In this connection, the Chairman said that he had been associated with the Royal College of Surgeons as Censor at the examinations, and the distinguished President of that College would bear him out when he said that the desire of the Council and Examiners is to give every latitude to the students, while safeguarding the public health. In the Royal University he had the same knowledge of the subject, as he was associated there with two distinguished gentlemen, who were guests that evening. They would, he was sure, bear him out when he said that in the examinations no man would suffer in whose hands the lives of the public would be safe. The feeling he had was that a man who shirked the ordeal of these tests at home should have no place in their ranks in Ireland. Dr. A. J. Smith seconded the toast, which was carried with acclamation. Other toasts and speeches followed, and after an enjoyable evening the company separated.

Royal College of Physicians of Ireland.

AT the stated annual meeting of the President and Fellows of the Royal College of Physicians of Ireland, held on St. Luke's Day, the following were elected for the coming year:—

President.—Sir William J. Smyly.

Vice-President.—Dr. E. E. Lennon.

Censors.—Dr. E. E. Lennon, Dr. A. R. Parsons, Dr. J. H. R. Glenn, Dr. W. R. Dawson.

Additional Examiners, to take the place of an absent Censor or Examiner:—

Medicine.—Dr. W. J. Thompson.

Medical Jurisprudence and Hygiene.—Dr. A. N. Montgomery.

Midwifery.—Dr. T. Henry Wilson.

Examiners for the Licence to Practise Midwifery.—Dr. A. J. Horne and Dr. Henry Jellett.

Additional Examiners under the Conjoint Examination Scheme.—Biology, Dr. E. MacDowel Cosgrave; Chemistry, Professor E. Lapper and Dr. N. Falkiner; Physics, Dr. W. A. Winter and Dr. G. J. Peacocke; Pharmacy, Materia Medica and Therapeutics, Dr. H. C. Drury and Dr. M. J. Dempsey; Physiology, Dr. H. C. Earl; Pathology, Dr. A. C. O'Sullivan; Medicine, Dr. J. Murphy and Dr. R. Travers Smith; Hygiene and Forensic Medicine, Dr. H. T. Bewley.

Examiners for the Conjoint Diploma in Public Health.—Hygiene, Dr. H. T. Bewley; Chemistry, Professor E. Lapper; Meteorology, Dr. W. A. Winter. Extern Examiners in Preliminary Education—Mr. E. H. Alton, F.T.C.D., R. A. P. Rogers, F.T.C.D., and the Rev. Professor Murphy, M.A.

Representative on the General Medical Council—Sir John Moore.

Representatives on the Committee of Management—Dr. Walter G. Smith, Sir John W. Moore and Dr. James Craig.

Treasurer—Dr. H. T. Bewley; *Registrar*—Dr. James Craig. *Librarian*—Mr. R. G. J. Phelps. *Architect*—Mr. A. E. Murray, C.E. *Law Agents*—Messrs. Stephen Gordon and Son. *Agent to the Trust Estate*—Mr. C. U. Townshend, J.P.

The annual dinner of the College was held on Saturday, the 21st inst., and was very largely attended. Prior to dinner the President admitted to the Honorary Fellowship of the College The Provost of Trinity College and Sir Douglas Powell, Bart., K.C.V.O. Professor Osler, who has also been elected to the Honorary Fellowship, was unavoidably prevented from being present, and in consequence his admission was postponed until a future date.

Royal College of Surgeons of England.

THE annual meeting of Fellows and Members will be held at the College in Lincoln's Inn Fields on Thursday, the 16th November, at 3 o'clock p.m., when a report from the Council will be laid before the meeting.

Fellows and Members can obtain copies of the Report on application to the Secretary and can, if they so desire, register their names as wishing to receive the Report annually.

Motions to be brought forward at the meeting must be signed by the mover, or by the mover and other Fellows and Members, and must be received by the Secretary not later than the 6th of November.

Pass Lists.

Royal University of Ireland.

MEDICAL DEGREES EXAMINATIONS.—The Examiners have recommended that the following candidates be adjudged to have passed the undermentioned examinations respectively:—

The M.B., B.Ch.,B.A.O. Degrees Examination.—*Upper Pass*—Foster Coates, B.A., Arthur G. Cummins, James S. Dickey, James Donelly, Rodolphus W. Harper, William Irwin, B.A., Robert S. Kennedy, James Macarthur, Campbell G. Robb, Patrick Steen, Harry C. Watson. All the above may present themselves for the further examination for honours.

Pass—James A. Beamish, Herbert W. Carson, John Derane, James Flack, David H. C. Given, William R. Hayden, Robert L. Keown, Andrew Leitch, James McCloskey, Edward M. O'Neill, Thomas M. Phillips, Stephen B. Walsh, B.A., James F. McDermott. Exempt from further examination in Medicine Group.

The M.D. Degree Examination.—William J. Bannister, M.B.,B.Ch.,B.A.O., Sydney H. Blakeley, M.B., B.Ch., B.A.O., Thomas H. Delany, M.B., B.Ch., B.A.O., Samuel R. Hunter, B.A., M.B., B.Ch., B.A.O., Francis E. McCune, B.A.,M.B., B.Ch., B.A.O., Adam Moss, M.B.,B.Ch.,B.A.O.

Notices to Correspondents, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

Fitzroy.—The usual method is to call the staff together, and if the facts after due inquiry appear to warrant such a step, to move the suspension of the offending member. The step is doubtless extreme, but sharp diseases demand sharp remedies. The relative position of hospital juniors is, and has always been, most rigorously maintained. In the large London Hospitals practically they have no voice in medical matters.

THE LATE CARMICHAEL COMPETITION.

To the Editor of the Medical Press & Circular.

Dear Sir,—Will you give me space to state that the opinion of eminent counsel having been obtained, that opinion is emphatically against the legality of the late award. The ground is that the award was *ultra vires*. I have been in communication with some of the competitors. Would those who have not already written to me do so now so that united action may be taken?

I am Sir, Yours truly,
Thomas Laffan.

Cashel, Oct. 18th.

Dr. Haig.—The atrophy of the bones apparent in the Röntgen photograph is a well recognised condition following disuse of the limb. It is recognised by the faintness of the osseous shadow when compared with that of normal bone, and by the pencilled outlines.

T. A. S. (Lincoln).—The question is somewhat difficult to answer without full possession of the facts pro and con. Write to Dr. Bateman, Secretary to the Medical Defence Union. Even if you are not a member he would probably advise you how to proceed.

Apothecary.—A licentiate of the Society of Apothecaries is entitled to put Physician and Surgeon upon his door-plate. He has been duly examined and a diploma of being qualified to practise granted in both branches of the medical art.

Dr. H. (Freshford).—While we can see no objection to a medical officer joining the Poor Law Association if he so desires, we desire to point out that the natural association for a medical man situated as you are to join, is the Irish Medical Association, which we understand will shortly be reorganised and established on a basis even firmer than before.

THE ADDRESS AT ST. VINCENT'S HOSPITAL

Sir,—In your notice of the above, Medical Press, Oct. 18th, you give a necrology including my name which is correct. In *another journal*, however, I am described as one of the original staff—it was formed more than a year before I was born. Permit me to correct this error.—Yours, &c., E. D. Mapother, 16 Welbeck St., London, W.

A. F. S. (York).—Benger's Food is the most suitable in the case to which you refer.

H. P. B. (Liverpool).—The statistics of the hospital referred to, would be more reliable for comparison were the points to which our correspondent (C. H. S.) drew attention in our issue for the 4th inst. explained.

Mr. R. Millson.—The population of London proper is officially estimated at 4,684,794; but if your inquiry relates to Greater London, including its suburbs, the population reaches over 7,000,000, and if extended still further to what is known as the "outer ring" an addition of 2,325,378 persons must be made.

Meetings of the Societies, Lectures, &c.

Wednesday, October 25th.

Hunterian Society (London Hospital, not at Guy's Hospital as was previously arranged).—4 p.m. Clinical Afternoon.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. J. Pardoe: Clinique. (Surgical.) 5.15 p.m. Mr. Collins: Intra-Ocular Tumours (with lantern slides).

Post-Graduate College (West London Hospital, Hammersmith Road, W).—5 p.m. Mr. Bidwell: Floating Kidney.

North-East London Post-Graduate College (North-Eastern Fever Hospital, St. Ann's Road, N.).—2.30 p.m. Dr. Turner: Demonstration on Fevers.

Thursday, October 26th.

Harveian Society of London (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Papers:—Mr. H. Tilley: The Symptoms, Diagnosis, and Treatment of the Commoner Forms of Nasal Obstruction.—Mr. E. W. Brewerton: Extirpation of the Lachrymal Sac.

Neurological Society of the United Kingdom (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Clinical Evening. Patients in attendance at 8 p.m.

British Balneological and Climatological Society (20 Hanover Square, W.).—8.30 p.m. General Meeting. 9 p.m. Presidential Address:—Dr. G. W. H. Cumming (Torquay): The Influence of Climate upon Old Age and Senile Diseases. Paper:—Dr. R. W. Felkin: Sea Voyages for Invalids.

Childhood Society and the British Child Study Association (Parkes Museum, Margaret St., W.).—8 p.m. Dr. C. Reddie: Some Causes of Physical, Mental, and Moral Degeneration. (Arranged by the Childhood Society.)

Medical Graduates' College and Polyclinic, (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. A Morison: The Nature and Treatment of the Attack in Spasmodic Asthma.

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Ll. Williams: Pain and Swelling in the Mouth.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Seborrhœa and Psoriasis dealt with as Stages of the same Dermatitis in Symptoms, Diagnosis, and Treatment. (Chesterfield Lecture).

Mount Vernon Hospital for Consumption and Diseases of the Chest (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. J. E. Squire: Pulmonary Tuberculosis in Children. (Lecture II.) (Post-Graduate Course.)

Friday, October 27th.

Clinical Society of London (20 Hanover Square, W.).—8 p.m. Exhibition of Clinical Cases followed by discussion. Patients will be in attendance from 8 to 9 p.m.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. H. Tilley: Clinique. (Throat.)

Post-Graduate College (West London Hospital, Hammersmith Road W.).—5 p.m. Dr. Russell: Nephritis. (Lecture II.)

North-East London Post-Graduate College (Tottenham Hospital, N.).—4.30 p.m. Lecture:—Mr. R. P. Brooks: Diseases of the Optic Nerve.

Vacancies.

Leeds General Infirmary.—Laboratory Curator. Salary £200 per annum. Applications to Thomas Blair, General Manager.

Parish of Leicester.—Resident Assistant Medical Officer (Poor Law Infirmary). Salary £130 per annum, with rations, apartments, and washing. Applications to Herbert Mansfield, Clerk to the Guardians, Poor Law Offices, Leicester.

Birmingham City Asylum, Rubery Hill, nr. Birmingham.—Male Assistant Medical Officer. Salary £150 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Nottingham General Hospital.—House Surgeon. Salary £100 a year, with board, lodging, and washing in the Hospital. Applications to the Secretary.

Bristol Royal Infirmary.—House Surgeon. Salary £100 a year, with apartments, board and laundry. Applications to W. E. Bodgett, Secretary and House Governor.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Resident Medical Officer. Salary £100 per annum, with board, residence, and laundry. Applications to W. M. Wilcox, Secretary.

Appointments.

Dingle, Percival Alfred, L.R.C.P.Lond., M.R.C.S.Eng., House Physician to the Royal Hospital for Diseases of the Chest, City Road, E.C.

Edmiston, J. F., M.B., Ch.B.Liverp., House Surgeon to the David Lewis Northern Hospital, Liverpool.

Gush, H. W., M.B., Ch.B.Edin., House Physician to the David Lewis Northern Hospital, Liverpool.

Lunn, W. E. C., Accident Room House Surgeon to the Royal Infirmary, Newcastle-upon-Tyne.

Mallam, H. G., M.R.C.S., L.R.C.P.Lond., Honorary Medical Officer to the Brighton, Hove, and Preston Dispensary.

McGavin, Laurie, H., F.R.C.S.Eng., Consulting Surgeon to the Tottenham Hotspur Football and Athletic Company Ltd.

Births.

Harper.—On Oct. 17th, at Stowmarket, the wife of Henry Cecil Harper, M.R.C.S.Eng., L.R.C.P.Lond. (née Heald), of a son.

Redmayne.—On Oct. 17th, at 13 Warrior Square, St. Leonards-on-Seas, the wife of Thomas Redmayne, M.B.Cantab., F.R.C.S., of a daughter.

Marriages.

Webb—Mitchell.—On Oct. 14th, at Leckampton Parish Church, Cheltenham, Hugh Webb, Lieut., R.A.M.C., Peshawar, India, son of Dr. Webb, of Hornsey, to Vera Welbank, only child of Thomas W. Mitchell, of White Lodge, Cheltenham.

Deaths.

Gill.—On Oct. 21st, at 11 Russell Square, London, William Gill, J.P. for the County of London, L.R.C.P., &c., aged sixty-six.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, NOVEMBER 1, 1905. No. 18.

Original Communications.

THE TREATMENT OF
ACUTE PERITONITIS. (a)

By M. K. G. LENNANDER,
Upsala.

THE most effective weapon in our combat with peritonitis is the ability to prevent it. In order to possess this power, we must master in every detail, however minute, all the various pathological conditions which we know may be possibly followed by an attack. And whenever we see cause to fear the onset of acute peritonitis, we should carefully try to diagnosticate the cause. In the course of the various abdominal affections, the diagnosis of what is known to clinicians as the "preperforative" stage—that is to say, the diagnosis of the first symptoms of a parietal lymphangitis and an acute peritonitis, should be, if made in good time, the most trustworthy means of combating the various infections of the peritoneal membrane. Accordingly, the "muscular defence," the profound localised sensibility, and possibly the cutaneous hyperalgesia of Head, constitute the most important indications. At this stage, operative suppression of a source of infection may be carried out with a degree of danger which is comparatively negligible. On the other hand, when the propagation of the infection has not been anticipated, its progress should, at the earliest possible moment, be arrested by suitable intervention.

With regard to the symptomatic tenderness of the abdomen, I believe that it is due to the irritation (mechanical, chemical, toxi-infectious, or microbic) of the sensory cerebro-spinal nerves of the abdominal wall—which pass in the subserous tissue, or into the membrane itself. This view explains the fact that remotely situated patches of peritoneum may be profoundly altered by inflammation without giving rise to any local symptoms. And, whatever the microbic diagnosis may be, I believe that advancing peritonitis should always be met by operation. Even cases of purely gonococcic origin are not so comparatively trivial as they have been described.

The term *diffuse* should be abandoned in descriptions of this inflammation; and, from the practical standpoint all cases of peritonitis should be referred to as either (1) encapsuled, or (2) free. In the former, the peritoneal surface beyond the limiting adhesions remains unaffected by the process. The latter may be of small superficial extent; and a purulent exudation may become sterile and surround itself by adhesions. We have then a "peritoneal abscess."

Free peritonitis, when it engages but a small area, and is completely accessible, calls for surgical interference just as does a peritoneal abscess.

In this discussion, I shall sometimes employ the term *migratory* peritonitis, instead of *progressive*—the latter recalling the fibrino-purulent progressive form described by Mikulicz, while the former suggests analogy with migratory erysipelas. In my idea of free peritonitis there is no migration—that is to say, no extension. But the danger of an extension of the infection is none the less present; it may be propagated by acute migratory lymphangitis, or by passage of the exudate into the abdominal cavity. There are, of course, many transition forms between the *free* and the *encapsuled*. When an operation is performed after a long course of the disease, we may have both types displayed in one patient, on account of the gradual formation of adhesions, and subsequent extension beyond the borders of these. In every diagnosis we should take into account: (1) etiology; (2) locality; (3) nature of the exudation; (4) form (encapsuled or free); (5) variety (migratory or non-migratory).

Apart from the resistance of the individual, the malignity of a case of peritonitis depends on (1) the etiology and virulence of the infection; (2) the abdominal region having been the first infected; (3) the epoch of surgical intervention. There are two conditions which above all must be specially feared in an acute peritoneal infection; *the passage of the microbes and their toxins in large quantity into the circulation*, and *intestinal paralysis*. The toxins paralyse the vaso-motor and respiratory centres. That of the former leads to a general vaso-dilatation of the abdominal vessels—the patient bleeds into his own abdomen. The plethora of the abdominal vessels doubtless constitutes one of the principal defences of the organism against infection from that region. It becomes dangerous only when it prevents other vital organs from carrying out their essential functions.

The peritoneal cavity is a vast lymph-cavity, which communicates in all directions with the lymph- and blood- capillaries of the subserous tissue. Absorption is most rapid in the central part of the abdomen and on the diaphragmatic part of the membrane; and lowest in the other peripheral parts of the abdomen. At the onset of a case of peritonitis, the rate of absorption is always increased. With the accumulation of exuded fluid it slows, or ceases altogether. In the latter event, there is a double advantage, the toxins are gradually weakened, while their absorption is checked. The most frequent check to absorption is thrombosis and compression of the lymph-spaces and capillaries, and the blood-capillaries.

(a) Abstract of a Paper read at the First Congress of the International Society at Brussels, September 18th to 23rd, 1905.

The formation of peritoneal abscess is not generally productive, at first, of general symptoms. There is no fever, and no albuminuria; even the leucocytosis may remain normal. The general symptoms arise with the production of the toxins, when the thrombotic deposits are re-absorbed, or the compression of the lymphatics and spaces has been removed. The intestinal paralysis which develops in all advanced cases is due to toxic poisoning of the ganglionic cells of Auerbach's plexus. This view is corroborated by the fact demonstrated by Magnus that the spontaneous movements of the smooth muscular fibres of the abdominal wall, longitudinal and circular, are suspended when deprived of the relations of that plexus, which is situated between the two muscular coats. The peristalsis of health is probably maintained by the reflex stimulation of the plexus of Auerbach, by the mechanical or chemical irritation of the intestinal contents.

The conditions of peristalsis vary with the varieties of peritoneal infection. With peritoneal abscess it is but little modified. Increase in the amount of pus may produce compression, with the symptoms of vomiting and ileus which characterise its existence. The latter is most likely to develop in cases of collections of pus within the cavity of the true pelvis. It is possible that a form of pressure paralysis may develop in cases in which the amount of œdema and infiltration of the muscular coats of the intestine is sufficiently great to prevent—mechanically—the contraction of the latter.

The intestinal paralysis is the most serious condition, next to that of considerable absorption of toxins and microbes. Even when very limited in area, it arrests the transit of the intestinal contents; the arrest causes them to become toxic, while their pressure tends to lead to thrombosis and the production of gangrene. It also increases the permeability of vessels and tissues, to toxins and microbes. The intestinal wall is then attacked on both sides by these agents, and the system is simultaneously intoxicated from the peritoneal cavity and the intestinal lumen. All these considerations tend to make clear the fact that an acute peritoneal infection occurring in the centre of the abdomen is much more dangerous than when located in the periphery. Hence, the great importance of distinguishing between *central* and *peripheral* peritonitis. Under the latter head we include those which occur in the sub-phrenic and lumbar regions, both iliac fossæ, and in the cavity of the true pelvis.

When the question of operation arises, a true mental picture of the existing state of things is of the utmost importance. I propose in future to test the excitability of the intestinal wall, not only by the effects of air, of lavages of physiological solution, of pressure of compresses, &c., but also by electricity and the use of Nothnagel's crystals of sodium chloride. When these produce but simple contractions, and not peristaltic movements, there will be reason to believe the plexus of Auerbach is paralysed. The prognosis is generally admitted to be favourable, or even very favourable, even in presence of large quantities of purulent exudation, when the surface of the intestine presents an approximately normal aspect, and is not paralysed anywhere. The prognosis is very unfavourable when there is little or no fluid exudate, while the intestinal loops are red, dry, dilated, and paralysed. In the first case, the toxins have been weakened and masses of microbes have been destroyed by leucocytes; while by the influence of the dead leucocytes the bactericidal properties of the exudate have been increased. In the second case, the toxins have been absorbed from the intestinal walls, as well as from the parietal and intestinal serous surfaces, and the systemic poisoning has been proceeding from both surfaces at the same time. Further complications may arise in certain cases, such as thrombosis of the portal or caval venous systems, acute pneumonia, pleurisy, pericarditis, acute yellow atrophy of the liver, embolism, &c.

The indications in the operative treatment of acute peritonitis are: (1) Evacuation of the fluid exudate; (2) suppression or neutralisation of the sources of infection—by extirpation, resection, sutures, plastic operations, drainage (with plugging); (3) cleansing of the infected areas of the abdominal cavity; (4) evacuation and drainage of the intestinal canal—when paralysis of its wall exists; (5) draining for a time, if possible, all the secretions of the affected part of the peritoneum, so as to keep the remainder of the surface of the membrane free from contact with them—which is generally easy with regard to the periphery, but almost impossible in its centre.

When the operation has been judged necessary, and that it cannot be carried out at once, the patient is placed in a warm bed; and in such a position that the peritoneal exudate shall gravitate towards the abdominal periphery. In the majority of cases, a reclining posture of the trunk, with elevation of the lower limbs, is most appropriate. The danger of thrombosis in the lower limbs is diminished, and the exudate collects in the sacral hollow or in the lumbar region. All food and drink are cut off, except, perhaps, very small quantities of warm water, to which a little alcohol has been added. The rectum is cleared—when necessary—by injection of pure oil, at the temperature of the body. When impacted with scybalæ, these are removed gently with the finger, beforehand. Morphine, subcutaneously, or opium, *per rectum*, may be used to allay pain. In the Upsala clinic, a patient before operation for acute peritonitis, receives by subcutaneous injection, 1 cgr. of morphine, 40 cgr. of camphor, and 1 or 2 mgr. of strychnine. The body is covered with scrupulous care. The operation table is warm, and displaceable in every direction. India-rubber gloves are used, and a physiologic solution of 0·9 per cent. at a temperature of 39° to 42° C. Moist asepsis is employed. When the intestines escape, they are wrapped in hot compresses, soaked in the physiological solution, which latter are covered with a thin india-rubber tissue, over which in turn are placed warm sterilised napkins or woollen pads.

For tamponade-drainage I employ lamp-wicks, with the interposition of one or two tubes of india-rubber. The wicks are everywhere separated from the abdominal wall by a layer of thin rubber tissue, which permits their withdrawal without pain. On the second day, instillation of oxygenated water through the drainage tubes is begun, with or without a little glycerine. At the end of forty-eight hours a gradual withdrawal of the wicks and drains is commenced, and a Nelaton's sound is used to keep the wound open to the bottom. The gradual removal of the wicks and drains for five or six days promotes a simple approximation of the viscera, and restoration of their contact with the abdominal wall. Great care should be taken all the time that no collection of purulent matter is allowed to form in any remote pocket.

With regard to general conclusions, the following may be specially noted :—

The great importance of a *precocious* and *detailed* diagnosis.

Operative intervention, when possible, should be adopted before the development of intestinal paralysis.

In every operation we should endeavour to discover and neutralise the exciting cause of the inflammation.

In presence of intestinal paralysis, we may choose between—*enterotomy* (one or several), with evacuation of the intestine during the operation ; *typhlo-* and *entero- stomy*, in form of oblique fistulæ ; and, in desperate cases, the *resection* of 0·5 to 2 metres (at most) of the paralysed intestine.

CASE OF
NEPHRECTOMY
FOR
HYDRONEPHROSIS.

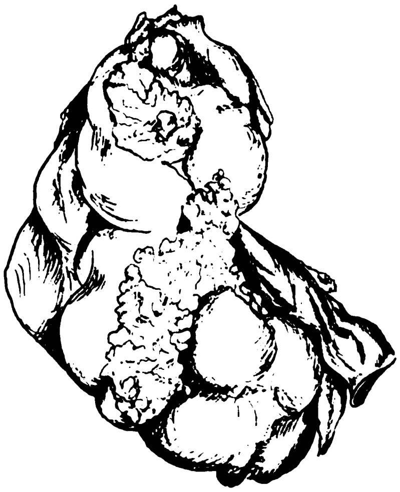
By DENNIS KENNEDY, F.R.C.S.I.,
Surgeon, Jervis Street Hospital and Children's Hospital, Dublin.

A. M., æt. 16, was sent to me by Dr. Cahill, of Dundrum, and admitted a patient to Jervis Street Hospital in September, 1904. The history of the boy, obtained from his mother, was as follows :—Up to the age of 4½ years he was a healthy child ; he then had an attack of typhoid fever, which lasted about four weeks. Soon after recovery he suffered from frequency of micturition, and pain during the act, and after a week he was taken to Pendlebury Children's Hospital, Manchester, where he remained an intern patient for four months. During his stay in Pendlebury he had two operations performed on him, from the last of which he was not expected to recover. He, however, left hospital perfectly well and remained so for two years. He then began to complain of pain about the abdomen and thighs, and was brought to Salford Royal Hospital, where he was declared to have nothing wrong with him, and was not detained a patient. He was now about seven years old, and for the next nine years he was never well. He always had some pain about the abdomen, and frequently had great exacerbations. Each week he had to spend at least two days in bed, from violent attacks of pain. During these attacks he sometimes lay curled up in bed, and sometimes became "convulsed," and covered with perspiration. The mother noticed on these occasions that the abdomen became swollen, and that the pain and swelling disappeared together.

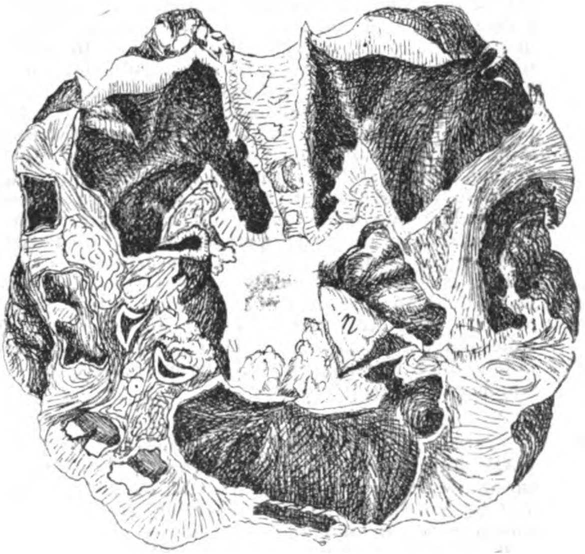
On examination, I found his condition as follows : He was a badly-developed lad for his age, and appeared not more than twelve years old. He was thin and haggard-looking, had a pinched face, and appeared dull and unhappy. His abdomen was distended below the umbilicus, was dull on percussion, but there was no tenderness. He had a scar over the left lumbar region, in the ordinary site for a lumbar nephrotomy. The pulse rate and temperature were slightly sub-normal. There was no marked swelling over either renal region, but there seemed to be some fulness on the left side. On passing a catheter I drew off one and a half pints of urine, and the abdominal swelling disappeared. There was not a trace of stricture or obstruction in the urethra, and the most careful sounding failed to detect a stone in the bladder. I kept him under observation for some time. The amount of urine secreted in twenty-four hours was about three and a half pints, was of specific gravity 1010, was acid in reaction, and did not appear to contain any abnormal ingredient. Each day, however, on passing a catheter, I withdrew at least a pint of residual urine, which the patient was unable to expel himself. Bowels acted regularly every day, and there was no vomiting.

I was inclined to look upon the case as being one of atony of the bladder, associated with diabetes insipidus. On seeing the lad, however, in one of his attacks of pain, the idea of such a diagnosis was at once dispelled. During these attacks he complained of pain over all the lower part of the abdomen, and in each renal region. He lay partly on his right side, with the legs drawn up ; he moaned with pain, and would frequently attempt to get out of bed. The abdominal muscles became somewhat rigid ; there was no definite swelling anywhere, but some tenderness and fulness were present over the left renal region. Neither vomiting nor rise in temperature was associated with the attack.

This drawing shows kidney seen from the back or posterior view.



Side View, showing a Couple of Inches of Ureter.



Kidney Laid Open.

These attacks lasted sometimes a few hours, sometimes for two days, with remissions, which were probably more marked on account of morphia administered hypodermically. They recurred at intervals varying from three to eight days. As the left renal region seemed to be the most probable site of the cause of the boy's trouble, and as it had been the site of a previous operation at Pendlebury Children's Hospital, I determined to explore it. Accordingly, the patient being prepared and anæsthetised, I made an incision extending from below the angle of the last rib forwards and downwards, avoiding the scar that was present. I quickly came down on what was evidently the kidney converted into a large hydronephrotic sac, filled with fluid, and I at once determined to remove it. Prolonging my incision anteriorly, and pushing the peritoneum towards the mid-line, I was enabled to come on the renal vessels and ureter. Having clamped and ligatured the vessels and double clamped the ureter, I incised the hydronephrotic sac and then enucleated it with some difficulty. Being anxious to find out the cause of the hydronephrosis, I passed a long probe down the ureter, but failed to reach any obstruction. Whatever it was, it must have been close to the vesical orifice. As the operation had already lasted close upon an hour, and as the lad was by no means a strong subject, I did not feel justified in prolonging the operation for mere exploratory purposes. I, however, stitched the mouth of the ureter to the edge of the cut muscle in order to facilitate exploration subsequently, should it be needed. I left in a gauze drain for forty-eight hours, and closed the wound with through-and-through sutures of silkworm gut. The wound healed by first intention. The boy's recovery was uneventful and rapid; he left hospital after four weeks; himself and his removed kidney being subsequently shown at the November meeting of the Surgical Section of the Royal Academy of Medicine in Dublin.

The specimen was examined for me by Dr. McWeeney. As can be seen by the drawing, it was hollowed out into several cavities, each communicating with the other by small openings. The secreting substance of the kidney had nearly completely disappeared. The ureter was greatly dilated and thickened. The tip of the little finger could be inserted with ease into the lumen, and the walls were like thick rubber tubing. The outer surface of the mass was very irregular, due to the presence of cavities beneath the capsule.

To know the exact cause of the trouble in this case is not easy, but the sequence of events points to the following conclusions. The boy got cystitis after his attack of typhoid, followed apparently by a surgical kidney on the left side. For this he was operated on in Pendlebury Hospital. A stricture of the ureter towards its vesical termination gradually developed, and subsequently the hydronephrosis. The attacks of pain were probably produced by the ureter at times becoming impermeable, and by excessive contractions of its muscular wall to overcome the obstruction supervening. The inability of the boy to empty the bladder completely would be due to his being unable to assist the bladder by contraction of his abdominal muscles. From six hours after the operation he had no trouble whatever in completely emptying the bladder.

• The drawings were kindly made for me by Miss Daisy Coghlan, a student of the Kildare Street School of Art. I was ably assisted at the operation by my colleague Mr. Byrne and by Dr. Cahill, to whom I am indebted for the case and for the exhaustive history which he supplied me with.

Reported Medical Discovery.

ACCORDING to the *Neue Freie Presse*, Dr. Geirsvold has announced to the Medical Association at Christiania that he has succeeded in discovering the bacillus of poliomyelitis, an inflammatory disease of the spinal cord which usually occurs in young children, and which causes paralysis of certain muscles or of an entire limb. As similar previous announcements have not been confirmed, the news has been received with reserve.

HOW TO STERILISE DRINKING WATER AND OTHER FLUIDS.(a)

By DAVID WALSH, M.D.,

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FOR many centuries the Thames has been famous as a salmon river, but it has been practically deserted by that fish for the last hundred years. The reasons for that extinction apply to various other rivers, and may be summed up in the two words—weirs and pollution. Of these two causes, pollution is far the more important. As a matter of fact, for many years past the lower reaches of the river have, more or less, resembled an open sewer. A vast deal of sewage also contaminates the higher reaches, where, unhappily, it affects men as well as fish, inasmuch as the Thames is the main source of the drinking water of the greatest city in the world. Yet Londoners in certain districts are content to drink Thames water after it has undergone extensive sewage contamination above the intakes of the water companies. It may interest them to learn that it is now possible to sterilise any drinking water supply, no matter how large, by the Salvator apparatus recently introduced from France, as well as several English machines of a similar type. If Londoners drink diluted sewage, let them at least insist on having it sterilised.

In the upper reaches contamination accrues mainly from storm waters and tributary streams. How many Londoners know that any town on a tributary stream, if three miles away from the Thames, is allowed to run the whole of its sewage into that tributary? Can the water consumers of London wonder that year after year they are saddled with a large sum-total of typhoid fever, for the most part of mysterious origin? In 1903 there were 2,339 cases of that disease notified in the Metropolis. As an instance of accidental pollution the following is given on the authority of an eye-witness. In June, 1905, the twin sewage ejectors at a town below Windsor broke down in storm time and floods of sewage poured into a stream running into the Thames. The town in question is above the water companies' intakes, so that sewage must have reached the London consumers on that occasion in larger quantities than usual. Now, had the waters of that contaminated stream been passed through a sterilising apparatus their danger of spreading disease would have been minimised. In the lower reaches of the Thames the amount of sewage discharged at Barking and Crossness may be reckoned in hundreds of millions of gallons. The solid matter is extracted, and were it possible to sterilise the effluent by a Salvator apparatus the gain to the river purification would clearly be great. The question is mainly one of cost in dealing with vast quantities of effluent. Every million gallons would cost about £11 to sterilise. Besides the main Metropolitan drainage, there are various smaller but still important sewage outflows, such as those of West Ham, West Kent, and of various villages and towns to be considered.

The purification of the Thames, then, closely concerns the health of Londoners as well as the restoration of salmon. To insist that the Thames, whose water we drink, should be made pure enough to let salmon live in it is surely not to impose too high a standard. Much has been done by the London County Council and the Thames Conservancy to purify the river, but a vast deal remains to be achieved ere we regain the lost heritage of a silvery Thames. A systematic sterilisation of sewage effluents and of polluted streams would help on the good work of the London County Council by leaps and bounds. Happily, the Salvator apparatus has placed the possibility of wholesale sterilisation of sewage effluents in the hands of sanitary reformers.

(a) A Paper read at the Public Health Congress, London, July 21st, 1905.

It is obvious that ordinary methods of purification of drinking water are rough and imperfect. For purification by filtration, practically the only means is the Pasteur filter, but that apparatus could not be used on a waterworks scale. Mechanical filter beds are apt to break down at any moment and to permit the passage of disease-producing bacteria with disastrous results. Enteric fever, cholera, diarrhœa, dysentery, the ova of intestinal parasites and other water-borne maladies may be thus distributed in drinking water. Let Londoners lay to heart the fact that the only trustworthy way in which water once contaminated with sewage can be rendered safe for drinking purposes is by boiling. Hitherto it has been impossible to deal in that way with water in bulk. That difficulty, however, has now been overcome by the apparatus introduced by Vaillard-Desmaroux.

The principle of the Salvator is to boil water under pressure as it passes through a series of pipes encased in a steam jacket. By means of a special device sterilised water is discharged continuously from the apparatus practically as cool as when it entered. At the same time, the water can (if wished) be deprived of more or less of its hardness. The machine is made to work with the utmost economy of fuel, and any ordinary source of heat may be utilised. As the sterilising is conducted under pressure, the natural solids and gases of the water are retained, so that the sterilised water issues forth bright, sparkling and palatable, forming a marked contrast from the flat insipidity of water that has been boiled or distilled. Water passed through the apparatus at ordinary tap pressure issues sterilised, cool, and palatable, and, if desired, also softened. Samples of sewage-contaminated water taken from any stream would, if thus treated, be rendered harmless so far as any living microbes were concerned. The safety of Thames water for drinking purposes could thus be ensured, whereas it now constitutes a standing menace to the consumer. Who can doubt that were a single case of Asiatic cholera to be imported into the neighbourhood of the Upper Thames that London would run the risk of a widespread epidemic of cholera?

In France, Surgeon-Major Sebillon, of the 1st Chasseurs, has published the following remarkable experience:—

"The Vaillard-Desmaroux apparatus was fitted up on September 22nd, 1895, in the cavalry barracks at Chateaudun, after an epidemic of typhoid fever, which had the most deadly effects on the military population. Bacteriological examination disclosed the presence of many bacteria in the drinking water, which was taken from the neighbouring tributary of the Loire.

"By using this water constantly typhoid is endemic among the civil population.

"On the arrival of my regiment, the 1st Chasseurs, in 1896, the situation was as follows:—From January to May of that year a virulent epidemic of typhoid fever had occurred among the 20th Chasseurs (one hundred cases with twelve deaths), whilst a less severe outbreak prevailed amongst the civil population.

"The commandant decided to leave the town, but whilst waiting the boring of an artesian well, 250 mètres deep, the corporation set up at its own cost a Salvator installation, this having been made a *sine quâ non* if the troops were to return to the town.

"Thanks to these steps we had not a single case of typhoid fever amongst the military population after September 22nd, although endemic typhoid continued amongst the townsfolk.

"In short, it has been demonstrated with mathematical accuracy that it is possible to preserve a garrison of 850 men for four years from typhoid infection, whilst residing in a known endemic centre, simply by using water freed from suspicious germs. This sterilised water, too, is clear, tasteless, and sparkling, and was used by the men without complaint."

Other experiences, no less striking, have been recorded. The French military authorities have adopted the system widely in camps, barracks, and prisons. It is worthy of note that the Japanese, ever ready to seize upon the best practical applications of our science, have used the Salvator apparatus largely throughout their present war, with the result that typhoid fever has been practically unknown among their troops in Manchuria. Had a similar method been in use among our own soldiers in South Africa, the disastrous loss from typhoid fever might have been avoided, or, at any rate, much lessened. Unfortunately, the Salvator system had not then been introduced into the United Kingdom. It is to be hoped, however, that our military authorities, who have ever shown themselves anxious to be in the forefront of scientific progress, will see their way to adopt the Salvator apparatus at home and abroad in unhealthy camps and barracks and on active service.

In the Navy the safety of a ship's drinking water obtained from shore might also be ensured by passing it through a sterilising apparatus. In this way the use of unpalatable distilled water from the engine might be avoided. A similar remark applies to ocean steamers, and, indeed, to vessels of all sizes. By the use of a miniature apparatus, which can be supplied at a cost of £10 or £15, even the ordinary river houseboat could obtain at all times a supply of absolutely safe, sterilised water. At present the occupants of houseboats as a rule drink contaminated river water passed through a filter, a precaution that simply makes bad water worse.

The sterilising power of the Salvator apparatus has been testified to by Mr. C. G. Moor, the well-known analyst. As the result of bacteriological examination, he reports that the water issuing from the Salvator is absolutely sterile, as against one thousand organisms per cubic centimetres in the unsterilised tap water entering the apparatus.

Reports to the same effect have been made by Dr. Thresh and Mr. Ernest Cassall, to say nothing of many distinguished French scientific men.

It is obvious that if a process of this kind can be applied on a large scale a new era will be brought about in the purification of drinking water supplies. Take the case of Lincoln, where a wholesale outbreak of typhoid fever followed sewage pollution of the river from a ditch above the intake of the town supply. A sterilising apparatus could have been erected within a few days, and the whole of the Lincoln water sterilised forthwith. In that way the primary infection of the reservoirs could have been effectually stopped. Instead of advising citizens to boil water in their kettles, the authorities would have boiled it in the apparatus before distribution. The cost of installation to the city would not have been great, probably a few thousand pounds; certainly it would have cost far less than the loss entailed by the sickness and death of many victims of the outbreak, to say nothing of the stoppage of industries and loss of trade to the whole community.

There are not a few polluted water supplies in the United Kingdom where an efficient sterilising apparatus would be invaluable. Many ancient dwellings—such as Windsor Castle—may in future have their drinking water rendered absolutely free from typhoid and other infections. Camps, barracks, warships, steamers, houseboats, schools, infirmaries, and other organisations may in this way ensure a permanently safe supply of drinking water.

There are various other ways in which the sterilising apparatus may be of use. The removal of a portion of the hardness from water would save yearly an immense amount in the soap now wasted in overcoming the excessive hardness of the water. Another important point is that water could be thus softened before being passed into large boilers. A great deal of the incrustation would be prevented, with a corresponding economy of fuel.

Milk can be sterilised in the apparatus quickly and well, and, above all, its flavour is not in the least spoilt. In this way may possibly be solved the problem of sterilising large quantities of milk for dairies and for municipal supplies.

Another field of incalculable usefulness lies in the sterilisation of sewage effluents into streams and rivers or into the sea. The London County Council and the Thames Conservancy have achieved a great deal towards the purification of the river. In the Conservancy report for the year 1904, for instance, we find it stated that during the year in question sewage from seven places, representing a population of nearly 14,000 persons, has been diverted from the streams connected with the Thames. The Conservators add that works for the purification of the drainage are now in operation at nearly all the towns and populous centres.

Take the case of the sewage effluent from Ealing. By an ingenious process the sewage of the district is sedimented, and the sludge burnt with house refuse in a destructor. The fluid effluent is aerated and discharged into the Thames. As a matter of fact the effluent must be saturated with obnoxious organisms. Ealing citizens are not to blame, for they have adopted, and, indeed, initiated, the best method available up to the present time. They can now come abreast of the most scientific modern lines by sterilising their sewage effluent. The proper way would be to run that effluent through a sterilising apparatus, which could be readily worked by waste heat from the destructor. Ealing is the type of a great number of towns that pollute the Thames by imperfectly created sewage effluents. The cost of sterilising such effluents would not be prohibitive.

In so practical question as the sterilisation of water price becomes a matter of the utmost importance. This applies more particularly to the smaller communities to whom, on the one hand, a penny rate yields less and is felt more than in large communities, and, on the other hand, whose smaller consumption would be purified at a less economical rate than that of a large population. The makers of the French apparatus have furnished the following table of the cost of the apparatus and of its upkeep in various sizes :—

Gallons per day.	Prime cost of works fitted with apparatus.	Cost for heat, lubrication, labour, &c.	
		Per day.	Per 1,000 gallons.
	£	£ s. d.	
25,000	1,400	8 4	4 pence
50,000	2,640	12 6	3 ,,
100,000	4,800	1 10 10	3.7 ,,
250,000	12,000	3 8 9	3.5 ,,
500,000	22,000	6 10 0	3.1 ,,

It will be seen from these figures that only moderate sums are necessary for the purification of the smaller supplies, and though it would undoubtedly require a large sum to instal and to maintain an apparatus for the sterilisation of a river drinking water supply, on the other hand a great saving would result in the lessening of typhoid fever, diarrhœa, and other diseases that would result. In comparison with the total cost of a large supply the cost of sterilising would be relatively small.

Great as the value of an apparatus for the rapid sterilisation of fluid in bulk must undoubtedly be in the United Kingdom, it would nevertheless be far greater in tropical countries. By sterilising the water supply in many parts of India or South Africa, for instance, not to mention other colonies and dependencies, a vast saving of life and health would be effected among both civil and military populations. Owing to the unspeakably filthy habits of the natives, drinking water is always open to the pollution of cholera, typhoid fever, dysentery, and other water-borne diseases. In future, any camp, station, or town in India can be supplied with an absolutely safe water supply by the installation of an efficient sterilising apparatus. From an economical point of view a vast pecuniary saving would be effected in the health of our troops in India alone.

In the year 1903 the Indian Army showed 1,366 cases of enteric fever, with 292 deaths. In South Africa there were 1,155 admissions with 138 deaths. The cost to the Empire of the sickness, invaliding, and death of these soldiers is great. Attempts have been made by the military authorities in both India and South Africa to sterilise the drinking water. The appliances, however, deliver water hot, insipid, and in limited quantities, which necessitates cooling and storage in tanks with attendant risk of pollution. The French apparatus, on the other hand, gives a continuous delivery of cool, drinkable water. In India soda-water has been found contaminated with bowel organisms. The Government aerated works in that country supply soda-water of good quality, but it would be safer to sterilise all water used for that purpose in a good steriliser. When attached to a camp or barracks the soda-water factory could easily be arranged so as to supply in addition sterilised water to the whole of the resident troops.

The general adoption of the Salvator or other approved apparatus would necessarily effect a great advance in practical sanitation and a great advance in public health practice. It brings within the grasp of the sanitarian a simple but efficient means of absolutely sterilising water and milk supplies, as well as ridding sewage effluents of harmful bacteria. It provides both military and naval authorities with a means of ensuring a far higher standard of health among soldiers and sailors at home and abroad, whether in time of peace or of war. Lastly, it brings within the reach of the County Council the possibility of rendering river water pure.

If only a few of these claims can be established they will render the London Congress of Public Health in 1905 to that extent memorable.

THE INCREASE OF INSANITY IN IRELAND AND ITS CAUSES. (a)

By M. J. NOLAN,

Resident Medical Superintendent, Down District Asylum, Downpatrick.

I.—PROLEGOMENON.

> " Yesterday, *This* Day's Madness did prepare,
> To-morrow's Silence, Triumph or Despair."
> OMAR KHAYYAM.

FOR the purpose of the following observations it is assumed that, apart from the unquestioned increase in the number of the certified insane in this country, as proven by undisputable figures, there is perhaps also, unhappily, a real increase in occurring insanity out of proportion to the population. The assumption cannot be supported by figures of unimpeachable accuracy; none such are available. It is not, however, unreasonable or far-fetched since English and Scotch statistics show a trend to a real increase even in the face of growing populations, whereas in Ireland there is the exceptional and lamentable condition of constant shrinkage in the gross population, with a relatively larger number of registered insane. The special statistics on the matter are of no very great value. They cover but a day, as it were, in the life history of the nation, and such as they are inherent circumstances have combined to render them peculiarly unreliable and misleading.

To start with, it is still far short of two centuries since the " lunatic " in Ireland became as such a legal entity. At the date of this tardy recognition he was crushed into gaol cells, later he was transferred to the workhouse wards, and thence, later still, to the district asylums, specially established for the purpose. During this progression the limitations of the word " lunatic " have been gradually extended to a vast degree. Public sentiment at first inspired by the apprehension of injury to society, subsequently was softened by humane sympathy, and educated by scientific knowledge, has at length combined to bring under care all who show obvious mental derangement. This evolution of public opinion was imperative in the march of true progress. To this end much well-meant, but not always well-conceived legislation has been enacted, influenced by the two great motive powers, the protection of society at large, and the protection of the individual who is a potential danger, not only to others, but to himself. The result of this admixture of essentionally selfish and altruistic motives has produced a burden never anticipated—the accumulation of a vast number of mentally afflicted persons maintained at a huge expense by the public purse. In the golden "good old days" of yore things went differently. Homicides there were whose maniacal fury was speedily cut short by the ready sword of self-defence. Suicides, too, who made successful exits to furnish object-lessons at the cross roads. Witches and "bewitched" found drastic treatment in the stocks and village ponds. Mattoids and paranoiacs secured the persecution or the glory their organised delusions craved for, in risings and revivals, in camp, in pulpit, or at the stake. The mentally deficient—the idiots and imbeciles—furnished the "village fool," and "the fun of the fair" in the showman's booth. The senile dement droned and drowsed to the death in the ingle-nook of the old homestead, for the spirit of filial duty still warmly flourished, and the sun-dial marked a long-drawn day of vacant hours, uncheckered by the pressure of events. Withal if life was lightly held it was abundant. Fecundity blessed families, flocks and crops alike quickly filling the gaps made by disease, and war, and blight. All this, at least, in England, where strenuous conflict alternated with restful periods of recrudescence. But how different in Ireland! Here stress, predominant, protracted and wearing, weakened men and things; wove bonds of strangulation. Through long dark centuries untiring Fate unwound an endless thread from her distaft, and with relentless rancour seem to spin the grave-clothes for every hope, ambition and effort.

(a) Being the first of a series of articles dealing with lunacy matters, specially contributed to the MEDICAL PRESS AND CIRCULAR

Ireland in the past has had many poetic designations—all tributes to the nobility, the piety and the culture of her people. One other title she bore in days now dim in her history—*Muig Innis*—the Island of Melancholy. To-day, alas! when so many of her children are bowed beneath the brooding burden of mental decay, she would seem to have again a pre-eminent right to this sad distinction. Not since those dawning days when Partholan's people settled on her shores, nor yet during the long intervening ages when the Gaels and Phœnicians, the Teutons and the Celts, the Fomorians and the Firbolgs, the Milesians and the Cruthneans, contended to build up the national character, did she fit so well her title of "the Island of Melancholy" as she does to-day. For it would seem as if, in this great psychical contest, the predominant strains, the complex Celtic influences, were forced into conflict, and that for the moment the inherent emotional sadness asserts itself in the plaintive wail of a wounded nation.

"What holds her fixed far eyes nor lets them range?
Not the strange sea, strange earth, or heaven more strange.;
But her own phantom dwarfing these great three;
More strange than all, more old than heaven, earth, sea."

And yet it is that at this same psychological moment Ireland, still shadowed by the ghost of the past, seems to be inspired (with the usual paramount paradoxical feature of her character) by the spirit of a bright hope for a glorious future.

In a country remarkable for the contrasts evident in its internal circumstances, in its local conditions, in its "eternal trefoil of history, religion, and politics" there is nothing so paradoxical as the national character wherein indeed lies the *fons et origo* of all the contrarieties which influence men and things. Not that the constitutional elements are in any sense unique; they are but the commonplace attributes of mankind. The peculiarity consists not in the nature of the elements which go to form the character, but in their approximation and disassociation in every varying degree. They contain within them the highest potentialities for success or failure, according to the nature of the stimulus which excites them to action. And with such elasticity of normal structure there must exist a tendency to emotional instability under undue strain, or stress, which constitutes the fundamental cause of all diseased mental operations.

Now, the history of our country is one unbroken record of stress from within and without. It is impossible, in estimating the mental stature of the people to-day, to shut out that history—the life history of a nation is the sequence of events which have elicited the characteristics of its people establishing its strong and its weak points, all tending to produce the contemporary mental constitution. Hence we must take well to heart that whether we read that history in the light of victory or defeat, *Stress*, continued and cumulative, fought on both sides all through and claimed its countless victims.

What, then, is the present-day character of the Irish Celt? Is the trend of his mental qualities to flourish or decay—"to triumph or despair?" To secure an unbiassed answer to the first query, we may summon as an up-to-date witness a traveller from another land, a keen and competent critic. He says of Ireland:—"Nevertheless, she keeps her ideals, her recollections, and her hopefulnesses. She concentrates her energies, and that is why the 'Isle of Saints' still flowers like a veritable garden of churches, while its population, incorrigible, ungovernable, and undaunted, carries its dreams through transfused memories of the past, and chimerical anticipations of the future, all the time indifferent to realities of the present, and to the dilapidated conditions which confront them." (*a*)

This picture may, perhaps, be slightly out of drawing, but the main features are truly produced. The ideals of bygone centuries are cherished with the exaggerated reverence exacted by all that is vanished and remote. The recollections are indeed many and varied, of kingly powers, of sanctity, of learning, of serfdom, of licence, and of ignorance. The "hopefulness" persists, always a splendid redeeming quality. It is with regard to the "concentrated energy" that the pencil of the artist is unfaithful, at least, in its interpretions; since the magnificent liberality which has restored the despoiled shrines of the people has in the main come from the toiling exile—very little comparatively from the lazy peasant at home. And in this misinterpretation a leading paradoxical quality has been missed—the comparative failure of the Celt at home; his marvellous adaptability and success abroad. "Incorrigible" he may be, but only in his tenacity to his traditions, be they good or bad. Restive of coercion in its widest as well as its more limited application, he is "ungovernable" in disposition—easier to lead than to drive. His "undaunted courage" springs from the veteran spirit of his long and bitter fight; to-day it is something of that which sustains him who leads a forlorn hope. Memories are permitted to crowd too largely on the mental canvas to leave inadequate room for present impressions; and from the emotions evoked from such memories are created the sanguine hopes of to-morrow. Such is the character of the Irish Celt to-day, faulty indeed as all national character is in varying degree, but still endowed to an unexampled extent with fine and noble qualities, in which lie the seeds of her perpetuation and regeneration. So we seem at least to others, not always as promising to our own home observers, although they may regard us with *bona-fide* interest and with a kindly eye.

Sir Horace Plunkett sums us up by stating:—"Whatever impression I may succeed in making upon others, I may here state that as the result of observation and reflection, that the Irish mind is suffering from considerable functional derangement, but, not, so far

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(*a*) "Sous la Couronne d'Angleterre." By Firman Roz.

as I can discover, from any organic disease." In conjunction with this, the Earl of Dunraven signs a second certificate of national mental disease :—" For half a century or more the best-equipped, mentally and physically, have been leaving Ireland. The survival of the unfittest has been the law in Ireland, with the inevitable result upon the race which statistics abundantly bear out."

Did we not feel that the Knight and the Earl saw poor Muig Innis distorted in "a maze of mirrors," we would shrink back from this Wiertz-like production. It was not across this canvas a generous heart guided a king's hand to write, in imperishable letters of gold, "For a country so attractive and a people so gifted we cherish the warmest regard." We cannot admit this "functional mental derangement" of the nation, nor still less that the survivors are of the unfittest. That most excellent institution, "the Bureau of Statistics and Intelligence" of "*the* Department," could not support either opinion by figures or evidence of any value. Yet the mistaken diagnosis is not remarkable or unpardonable. Not so long since in our pre-degenerate days, one who sang sweet melody (Tom Moore) also wrote the prosaic truth :—" The minds of some of our statesmen, like the pupil of the human eye, contract themselves the more the stronger the light there is shed on them." Sir Horace, feeling the pulse of the nation through the arm of the department, mistakes a normal psychological condition for "derangement." He fails to see that the national mind, so long concentrated on memories and on anticipations, in the absence of the solid material interests which he laudably endeavours to supply, is but *apparently* indifferent to his undertakings, and is not suffering from "considerable functional derangement." It needs, indeed, a very determined exhibition of concentrated energy on the part of the people to discard at once the memories of "Round Towers, Wolf Dogs, and Sun Bursts" for the prosaic realities of creamery produce, poultry schemes, and mean rainfall. And the Earl evidently has accepted, with the scant consideration that goes with good faith, the figures of the blue-books, figures which those who build up them alone know how fallacious they are, and how imperfect is the information underlying them. Yet, such as they are, a brief glance at them is necessary, more for suggestion than satisfaction. That we have degenerates in full proportion is true indeed ; that the emigration is a grievous drain of an invaluable national asset is painfully true also. That the mass of the people are mentally and physically robust, that the "unfittest" do not alone remain, shall be shown when the figures and causes of occurring insanity are considered.

(*To be continued.*)

Clinical Records.

HOSPITAL FOR WOMEN, SOHO SQUARE, LONDON. (a)

A Remarkable Case of Pulmonary Embolism.

Under the care of **Bedford Fenwick**, M.D., M.R.C.P. Lond.,
Physician to the Hospital.

This case is remarkable not only because of the rarity of the condition, but also because of the coincidence of its occurrence directly after a very minor operation.

E. C., æt. 53, who had had two children, the last being born thirteen years ago, was sent to the Hospital for Women under my care by Dr. McKendry, of Goodmayes. She gave a history of having suffered for the last two years from very profuse, irregular, and increasingly frequent losses. There was old cardiac mischief ; a rough systolic bruit being heard over the apex of the heart. Otherwise, her general condition was fairly good, except that she was markedly anæmic. There was a small polypoid growth projecting from the cervix, and the uterus was about twice the normal size, and nodular on the surface. On September 19th, she seemed fairly well, and under gas and ether the cervical growth was snipped off. There was no bleeding. She was under ether altogether about four or five minutes, and the operation probably did not take a minute to perform. When she was taken back to bed, she quickly recovered from the anæsthetic, but about eight hours later it was noticed that her pulse was increasing in frequency, that she could not sleep, and that the breathing was becoming rapid. She had no pain except a feeling of tightness across the chest. These symptoms steadily increased, until twelve hours after the operation, when the pulse was 130, the temperature had risen to 102, and the breathing was extremely rapid and shallow. The vaginal plug was removed, but there was no hæmorrhage, and the cervix was quite normal. She then became unconscious, and died eighteen hours after the operation.

At the *post-mortem*, the uterus and cervix were found healthy, except for the presence of several fibroids, and the other organs showed no disease ; but, on opening the heart, it was found that the tricuspid valves were thickened from old endocarditis, and on the edge of one there was a small rough calcareous outgrowth, about the size of a split pea. On this growth, an *ante-mortem* clot had formed, and continued upwards in the course of the blood stream in a long decolourised clot of cylindrical form, gradually tapering as it stretched up through the right ventricle into the pulmonary artery. There it bifurcated, and stretched for two inches down the left pulmonary artery, and for an inch and a half down the right, almost, but not entirely, closing both arteries. The ventricle was full of black *post-mortem* blood, both lungs, especially the left, were livid grey in colour, and œdematous.

I greatly regret that, by a mistake on the part of the house physician, the specimen was not saved, because it was most instructive, and as I only saw one similar case during the seven years I was on the staff of the Victoria Park Chest Hospital, it must be extremely rare. The chief interest to this Society lies in the fact that death occurred from this cause after so simple and slight an operation. I had written to Dr. McKendry to tell him I would remove the polypus, but that as there were other fibroids in the uterus it might be necessary afterwards to perform hysterectomy, if her profuse losses continued. If I had performed the major operation at once, the fatal result would have been debited to one's statistics of hysterectomy, as, indeed, occurred in one of the cases to which I propose to call the attention of the Society this evening, and in which the patient died of pulmonary embolism, when she had apparently quite recovered from an abdominal operation.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

Meeting held on October 27th, 1905.

The President, **Mr. Clutton**, in the Chair.

Mr. G. E. O. Williams (introduced by Dr. Batty Shaw) showed a case of Thoracic Dermoid. The patient, a woman, æt. 26, was admitted to University College Hospital in June, 1905, complaining that for the previous three months she had been very much troubled with cough, and had brought up "pink" expectoration. In addition she had lost weight, and so feared that she had "consumption." On closer inquiry she admitted that she had a "weak chest" all her life, and cough had been troublesome for the last eight or nine years. She also volunteered the statement that she frequently found that hair came up into the mouth, sometimes with the expectoration, sometimes independently: this occurred several hundred times during the last seven or eight years. When twelve years of age she was treated for *left*-side pleurisy : exploratory puncture was performed, and some fluid was removed. Physical examination of the chest shows that there is some prominence of the front of the chest to the *right* side of the sternum.

(a) Read at a Meeting of the British Gynæcological Society on October 12th, 1905.

The percussion note is dull over the upper part of the right chest as far down as the fifth rib, and reaching from the sternum to the anterior axillary line on the right side. The breath sounds are greatly reduced above and below the right clavicle, and almost absent on the second, third and fourth spaces. Behind, there is only slight impairment of percussion note internal to the lower part of the right scapula, the breath sounds being a little weaker than normal at the right apex. No adventitious sounds are heard anywhere. The temperature whilst in hospital did not exceed 99°. There is a slight suspicion of clubbing of the fingers. The sputum is whitish in appearance, and is free from tubercle bacilli. Radioscopic examination shows a shadow over the dull area above indicated, which is lost on its inner side in the shadow of the sternum and vertebral column. Hair was expectorated on two occasions during her stay in the hospital.

Mr. W. L. **Spencer** described a specimen that was in Westminster Hospital. These tumours usually grew from the thymus.

Mr. **Rickman Godlee** mentioned a case he operated on in 1889. These tumours usually communicated with a bronchus, and so, if drained, never healed up, but remained moist. In the present instance, he was of opinion that it was too extensive for removal, but he advocated making a large incision with free drainage.

Dr. H. **Batty Shaw** said that seven cases had been operated on. Two had been completely cured, one by removal of the tumours and one by drainage.

Dr. **St. Clair Thomson** showed three cases of Submucous Excision of Deviations and Spurs in the Nasal Septum. The operation to which the patients had submitted was as follows:—An incision is made through the mucous membrane, inside the columella of the nose, and parallel to it. Through this incision the muco-perichondrium is separated all over the convexity. The cartilage is then cut through, a little in front of the original incision, but without incising the muco-perichondrium of the opposite side. The mucous membrane and perichondrium is separated from the concave side of the deformity. The deviation, thus freed on both sides from its mucous covering, is cut out; any bony spur is clipped or chiselled away, and the two mucous membranes are allowed to fall together. The original incision is then closed by two or three stitches. Healing is rapid, there is no formation of crusts, the nose is left with an intact mucosa, and the result is always satisfactory and permanent.

Mr. **Edred M. Corner** showed several Cases of Recovery without Spinal Symptoms, after Severe Injury to the Neck.

1. Case of Fracture of the Pedicles of the Axis: This case with skiagraph was shown at a meeting of the Society on January 22nd, 1904. The accident was the result of rolling out of his chair whilst sleeping on Sunday afternoon. The lesion was demonstrated in a skiagraph. Since being shown here, he has recovered full power of movement of his neck, and began driving his cab again twelve weeks after the accident.

2. Case of Fracture of the Body and Pedicles of the Fifth Cervical Vertebra: This case with skiagraph was shown at a meeting of the Society on January 22nd, 1904. The accident occurred during a gymnastic display on the stage. There never were any paralytic symptoms. After he had recovered from the accident he complained of some obscure and painful sensations in the back of his shoulders and down his left arm. Since being shown he has resumed his occupation as a professional acrobat, but still complains of pain at the back of his left shoulder.

3. Case of Rotatory Dislocation of the Atlas: This case with skiagraph was shown at a meeting of the Society. He was thrown from his horse, but was only slightly concussed, and rode home. There were no paralytic symptoms. His head is still turned to one side, but he has to some extent recovered the power of movement. From an examination of the skiagraph at the meeting at which he was first shown it was generally thought that there was no fracture of the odontoid process.

4. Case of Lateral Fracture of the Axis with Unilateral Rotatory Dislocation of the Atlas: This is a specimen which, besides the above lesion, shows at least one fracture of the atlas, and also by the signs of healing that the subject of the injury lived. Moreover, the displaced fragments made new articular facets for themselves, so that there was no paralysis in this situation, and therefore presumably none elsewhere. This specimen is brought as it is of particular interest in connection with the living cases shown along with it.

5. Case of Subluxation of the Atlanto-axial Joint: This case is that of a boy thirteen years of age who hurt his neck while diving. His head was rotated to one side, and his neck was stiff, painful, and immovable. He was seen a month after the accident, and had never had any paralytic symptoms. Reduction was easily accomplished under an anæsthetic. The boy wore a poroplastic collar for a week or so, since when he has completely recovered all his movements, so that it would be impossible to know that he had received a severe injury to his cervical spine.

6. Case of Lateral Fracture of the Axis: A man of fifty years of age was thrown from his horse on to the top of his head. There were no paralytic symptoms The injury took place about seven years ago. He has now recovered full movement, and experiences no trouble from his injury. The skiagraph shows anchylosis and deformity of the axis.

Mr. C. **Hilton Fagge** considered that the specimen showed by Mr. Corner was certainly one of caries, whether tuberculous or otherwise. As to the clinical cases, he was disposed to doubt the diagnosis, seeing that the only evidence was that of the skiagrams, which in these cases were notoriously unreliable.

Mr. **Corner**, in reply, said that the skiagrams had been submitted to the Society, and adjudged to show signs of fracture. As to the specimen, he thought that the facts of a dislocation being present at the right atlanto-axial joint and a lesion between the base of the odontoid process and the left atlanto-axial joint were decisive evidences of fracture, as such changes hardly ever occurred in disease.

Dr. R. O. **Moon** showed a case of Stokes-Adams Disease. The patient was a man of 60. Five years ago, while on some scaffolding, he fell backwards in a faint. A week later he had another similar attack. After that they recurred at intervals of six months until June, 1903, when they came on with great frequency. In the attack he would fall to the ground with the suddenness of an epileptic seizure, remain unconscious for half a minute, and on regaining his senses feel perfectly well. There have been twitching movements on several occasions, but he has never bitten his tongue or passed his water. During the last year the attacks have been decidedly less frequent, but he suffers a good deal from vertigo. The pulse is regular and very slow; the rate is usually 28, but it has been as low as 24, and as high as 36. It is apparently unaffected by posture or exercise. The cardiac impulse is very feeble, and there is a soft mitral systolic murmur at the apex, which, however, was not present when he first came under observation, June, 1904. There is no albuminuria, and the optic discs are healthy. There is no history of lues. He has been a man of regular habits, except as regards smoking; after the age of forty he became a very heavy smoker till two years ago.

Dr. **Alexander Morison** objected to the word epileptic in this connection, as the fits were epileptiform, being due to sudden blanching of the brain.

Dr. **Moon**, in reply, agreed. He remarked that in the fits occurring in the present patient, the pulse did not get slow, as it typically should.

Dr. G. A. **Sutherland** showed a Japanese Infant, showing the Congenital Pigmentation of Mongolians. The patient is a female infant, æt. 10 months, of pure Japanese descent. Over the scalp the hair is long, straight, and black, and it extends as a soft, downy growth over the forehead and in front of the ears. The skin over the lower part of the sacrum is of a dark blue colour, and a similar pigmentation, but of a lighter colour, extends over the buttocks. Smaller areas of blue pigmentation are present along the spine and behind the left shoulder, and there is one patch on the dorsal surface of the left hand.

Mr. George Pernet said that these changes were found in the infants of China, Japan, the Philippine Islands, and Western Greenland. Pathologically the pigmentation was in the corium, and not in the papillary layer. It was present from the fifth month to the second year, rarely longer.

Mr. W. G. Spencer showed two cases of Lupus becoming Epithelioma after repeated Surgical and Prolonged X-ray Treatment. 1. Lupus becoming Epithelioma in a Girl, æt. 15 years, after repeated Surgical and prolonged X-ray Treatment: At the age of six a bluish swelling formed on the gum of the upper jaw, which looked like a myeloid sarcoma, and histologically appeared to be a sarcoma without giant-cells. The disease having recurred several times it was recognised as lupus. It spread to the interior of the nose, then to the outer surface, the eyelid and forehead. The X-ray treatment was commenced about three years ago, and was immediately followed by healing except for some persisting islands. Lately the ulceration has recurred, the X-rays now excite ulceration and sloughing, the edges of the ulcers are becoming indurated and everted, and the epithelium seems to be growing downwards.—2. Lupus becoming Epitheliomatous after Surgical and X-ray Treatment: A woman, æt. 35. Lupus commenced in the right parotid region twenty-two years ago, and was treated by scraping under anæsthesia. Nineteen months ago the X-rays were applied, on one occasion for ten minutes. A burn resulted, and then a swelling, which later spread downwards below the angle of the jaw, forming an abscess, which was incised. The ulceration begun to fungate about ten weeks ago, and on October 17th a piece removed was found to be epitheliomatous.

Mr. Cecil Leaf described a case of lupus which had been present for eleven years, that developed cancer after three exposures to the X-rays. Dr. Norman Walker had showed three such cases before the Edinburgh Medico-Chirurgical Society.

Mr. Campbell Williams had seen similar cases. He drew an analogy between the conditions and xeroderma pigmentosa.

Mr. George Pernet said that the occurrence was extremely rare, and no commoner than cancer after any other granulanoma, such as gumma. Several such cases had been described, however, in Germany.

Mr. Spencer said that many years ago Mr. Hutchinson had described such cases after ephilides and lupus.

Mr. Lawrie McGavin showed a case of a man, æt. 42, who had an epithelioma of the lip. From its rapid evolution it had at first been mistaken for a chancre. The initial lesion resembled a blister.

Mr. Lawrie McGavin showed a man, æt. 44, who had had a rodent ulcer treated with the X-rays. The ulcer had been present for eight years, and as the patient refused operation, he had been treated with the X-rays. The result was most successful, for after nine applications the ulcer appeared to be quite cured.

Mr. Clutton said that, as a rule, the knife should be preferred to the X-rays, as frequently cases apparently cured returned later with a recurrence.

Dr. A. E. Garrod showed a case of Peculiar Pigmentation of the Skin in an Infant. A female child, æt. 2½ years. Has never sat up nor talked. There is some spasticity of the limbs, and when the child is placed upon its feet the legs are held crossed. The pigmentation is linear, and in some parts the lines are arranged in whorls; it is symmetrical in distribution, and does not follow the course of nerves. It had developed at the age of one year.

Dr. A. E. Garrod also showed a case of Cyanosis with Dextrocardia but no Cardiac Murmur. An infant, æt. 7 months, has been cyanosed from birth. The dextrocardia may be demonstrated by percussion, and is proved by examination with X-rays. There is no cardiac murmur at any orifice. The other viscera are not transposed.

Mr. V. Warren Low showed a case of Supra-acromial Dislocation of the Outer End of the Clavicle.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held October 20th, 1905.

Dr. Lewis in the Chair.

Mr. P. Lockhart Mummery showed a case of UNILATERAL AND BILATERAL PERSISTENCE of the fourth branchial cleft, in a girl, æt. 6. There is a minute opening on both sides of the neck just at the anterior border of the sterno-mastoid muscles. Closely associated with the sinus in its whole length there is a hard bar of cartilage which can be distinctly felt under the skin. On the left side there is a cyst about the size of a hazel-nut. From the opening on the right side there is a discharge of clear mucus, while from the left opening there is a milky discharge. In this case an hereditary factor can be traced through two generations.

In the second case there is a small opening in the skin on the right side of the neck at the anterior border of the right sterno-mastoid muscle. From this opening a thick cord can be traced upwards and ending above in a cyst. Pressure on this cyst causes a yellowish discharge to escape from the opening below.

Dr. T. R. Whipham showed a case of LYMPHADENITIS in a girl, æt. 2 years 1 month. Glands in the cervical axillary and inguinal regions stated to have suddenly enlarged two months ago, accompanied by rise of temperature, malaise and anorexia. Glands still further enlarged during the next month, with increase in size of liver and spleen. The temperature kept irregular and in the sixth week rose to nearly 105° F.

Dr. Whipham also showed a case of SPLENIC ANÆMIA in a girl, æt. 8, who attended the Evelina Hospital for wasting rickets in infancy. She has been in hospital on and off during the past year with marked anæmia, occasional enlargement of the spleen, irregular high temperatures and frequent vomiting.

Dr. J. Porter Parkinson showed cases of SPLENOMEGALY in a boy, æt. 11, and his sister, æt. 1. The boy had had a very enlarged spleen for ten years, and at the present time the liver was slightly enlarged, and there was slight jaundice, the red corpuscles of the blood were diminished, but the colour index normal and there was slight leucocytosis. The infant had anæmia with leucocytosis and a very enlarged spleen. There were also signs of rickets. The clinical features resembled splenic anæmia, but the blood change was not characteristic of that disease, while jaundice which existed in one of the patients is not found in true splenic anæmia.

Dr. Edmund Cautley showed a case of SPLENIC HYPERPLASIA in a girl, æt 8, with anæmia, a large prominent abdomen, much enlarged spleen and enlarged liver. A hæmic murmur is heard over the heart. No cause can be found in the family or past history of the case. Possibly the very carious teeth had some effect. Marked leucopania.

Mr. W. Miller Burgess showed a case of CONGENITAL TUMOUR OF THE ARM, probably lipoma, in a girl, æt. 3 years 2 months. Tumour noticed three weeks after birth on the right arm, consisting of three small lobes the size of peas, movable, painless.

Dr. G. A. Sutherland showed two MONGOLIAN TYPES: (1) A pure Japanese female infant, æt. 10 months; and (2) a Mongolian imbecile, æt. 2 years 8 months. He referred to the name of Mongolian imbecile, which was used because of certain facial appearances in this form of imbecility which were suggestive of a Mongolian origin. While the Mongolian imbecile of English extraction was to be regarded as a pathological product, the Eastern Mongolian was the physiological product of a pure-bred race. The Japanese baby, however, possessed certain features of anthropological interest, in the shape of blue pigment spots scattered over the back, and specially well marked in the sacrogluteal region. These pigment spots were well seen in the baby shown, there being a large blue patch over the buttocks, and some smaller spots over the back and shoulders, and one on the dorsum of the left hand. Regarding this pigmentation it was stated that it might increase in extent for some months after birth, but usually disappeared entirely during the first few years of life.

Dr. **Sawyer** read the notes and exhibited the specimens of a case of a

DIFFUSE ANGIOMATOUS CONDITION OF THE LIVER

in a boy æt. 7. A lantern demonstration of the microscopical appearances of the liver and other organs were given. The liver showed a most marked degree of cirrhosis, and throughout the organ an angiomatous condition was present.

Dr. **George Carpenter** showed two cases of

CONGENITAL HYPERTROPHIC STENOSIS OF THE PYLORUS.

The first case was seen at three weeks old, the pylorus then being of stony hardness. Symptoms commenced when a fortnight old. Eleven days later Mr. Ewen Stabb performed Loretta's operation, the pylorus then admitting the little finger. The child died fifteen days afterwards of starvation. The second child was five weeks old and symptoms commenced immediately. A lump of stony hardness was felt at the pylorus as also thickening of the stomach walls. The child was operated upon by Mr. Lockhart Mummery the following day by gastro-enterostomy. The child died a few hours after the operation.

Dr. **Edmund Cautley** reported three cases of

CONGENITAL HYPERTROPHY OF THE PYLORUS,

which had been treated by pyloroplasty on the 29th, 53rd, and 61st days of life. The first weighed about five and a half pounds before operation. He recovered, but died subsequently, on the 54th day, from an attack of ileo-colitis. The other two were very wasted infants. One died five hours after operation from collapse. The other died suddenly on the fourth day, when apparently doing well. He also mentioned two private cases operated on when 28 and 35 days old, both of which had recovered perfectly. He showed the stomach and pylorus of a baby, æt. 11 weeks, who died from marasmus due to constant vomiting since birth, but with no evidence of pyloric hypertrophy or stenosis.

Dr. **G. Carpenter** also showed a Dermoid Tumour of the Mediastinum, which had been removed from a child of ten. The tumour, which was cystic, was the size of a large fist. The cysts contained a brown gelatinous material, and in one of them were hairs and sebaceous material.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held at Liverpool, October 20th, 1905.

Dr. **Lloyd Roberts**, President, in the Chair.

CARCINOMA OF THE CLITORIS.

Dr. **Lloyd Roberts** (Manchester) showed a specimen of cancer of the clitoris, the rarest growth affecting the external genitals, removed from a patient, æt. 31, who had noticed the presence of the growth for about seven years. Attention was called to the early age of occurrence, and to the absence of itching as a symptom. In these respects the case was in marked contrast to one he had shown during the previous session. The communication was illustrated by drawings and microscopic preparations.

Dr. **G. Whittle** (Liverpool) considered that in cases of this kind itching was a separable accident, having no direct correlation with the cancerous nature of the disease.

ASCITES IN CASES OF FIBROMYOMA UTERI.

Dr. **H. Briggs** (Liverpool) showed two fibromyomata removed from patients, æt. 35 and 40 respectively, which were characterised by the presence of ascites. This symptom was explained, he thought in one case by the extreme narrowness of the pedicle, while in the other case the tumour was enveloped in omentum, which was extensively adherent to its surface. These circumstances both pointed to feeble nutrition of the growth, and Dr. Briggs inclined to associate the presence of ascites accompanying abdominal tumours, with low vitality rather than with malignancy. He mentioned a patient with fibroids in which the Salisbury treatment so lowered vitality that ascites occurred, only to disappear when the patient returned to her ordinary mode of life.

Dr. **A. W. W. Lea** (Manchester) mentioned a patient, æt. 44, with a remarkable amount of ascites, who was found to have a firm uterine growth filling the pelvis and abdomen half way up to the umbilicus. Sarcoma of the uterus was diagnosed, and both ovaries were removed. A perfect recovery followed, as the ascites never returned, and the tumour shrank so that the uterus again became freely movable. As no recurrence occurred within five years, it was clear that the case was one of fibromyoma with ascites.

Dr. **J. W. Martin** (Sheffield) had recently seen a large multilocular ovarian tumour of innocent nature which was accompanied by a large quantity of ascitic fluid. The vitality of the growth had been lowered by the stretching of the pedicle from one side of the body to the other. This case favoured the view that feeble nutrition, rather than malignancy, determines the occurrence of ascites in cases of abdominal new growth.

Dr. **Briggs**, in reply, compared the ascites to that which is caused by cirrhosis of the liver, pointing out that while the one is cured by removing the tumour, the other can be surgically treated by improving the circulation of the liver.

Dr. **Briggs** also showed a rudimentary uterine horn, a large sarcoma of the uterus and drawings illustrating two cases of accidental hæmorrhage.

Dr. **Gordon W. Fitzgerald** (Manchester) read a paper on "Lacerations of the Vagina during Parturition."

Dr. **W. K. Walls** (Manchester) and Dr. **W. E. Fothergill** (Manchester) mentioned cases in illustration of the subject.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, October 29th, 1905.

ULCERATIONS OF THE TONGUE.

Nothing is more difficult at times than to make a correct diagnosis of ulcerations of the tongue, and in no malady, perhaps, is it of more importance in view of subsequent treatment, and especially in cases of cancer, where an early operation can prolong the life of the patient. Ulcerations of the tongue may be divided into four principal types: Ulceration of dental origin, tuberculous ulceration, syphilitic ulceration, cancerous ulceration. In all these different forms an important point to consider is the existence or non-existence of an indurated base to the ulceration.

Ulceration of dental origin is frequent and due to irritation with excoriation of mucous membrane of the tongue by the presence in the month of a decayed tooth with sharp edges. It is seated directly opposite the offending tooth, and does not present an indurated base. The bottom of the ulcer is covered with little granulations of a healthy aspect. The salivary secretion is not increased, and, as Duplay says, never do there exist painful irradiations towards the ear as in the case of cancer. Avulsion of the tooth produces a prompt cure.

Syphilitic ulceration of the tongue can be observed under different forms—chancre, mucous patches, tertiary accidents. Chancre develops rapidly. It is generally seated at the point, secretes very little, and rarely bleeds; the edges and base are indurated, while the sub-maxillary ganglions are considerably developed. Mucous patches are easily recognized, being superficial and serpiginous. According to Prof. Duplay, the gommæ of tertiary syphilis present the most difficulty for diagnosis. In general, it takes the form of an indolent tumour seated on the middle of the tongue, rarely on the edges. This tumour progresses gradually, bursts, leaving behind an ulcer of well-defined edges, greyish yellow colour, and almost painless. Generally the diagnosis can be enlightened by the presence of other syphilitic signs and frequently the patient himself furnishes the information desired.

Tuberculous ulceration of the tongue is generally posterior to pulmonary injection, the mucous membrane being inoculated by expectoration. Sometimes, however, the ulceration appears on the tongue before any other symptom of tuberculosis could be detected. The lesions do not present an indurated base; sometimes very painful, the pain shooting towards the ear of the same side. The ulceration is small, irregular, not very deep, and suppurates but slightly. The ganglions are not affected. One of the chief characteristics, and, to a certain extent, pathognomic of tuberculous ulceration, consists in the presence on the edges of little yellowish nodulæ of the size of a millet-seed undergoing caseous transformation. Microscopical examination of these nodulæ will reveal the bacilli of Koch.

Epithelioma is the cancerous type that is found most frequently on the tongue. The base of the ulcer is indurated, and the surface is covered with granulations which bleed at the least contact, the ulcer secretes fetid pus and the flow of saliva is greatly increased. This salivation causes great inconvenience to the patients, forming their chief complaint. Cancerous ulceration is accompanied always by great pain, irradiating to the corresponding ear, and which, by its persistence and violence, constitutes one of the most important elements of differential diagnosis.

The sub-maxillary ganglions are affected at an early date.

Local pain.—Salicylate of methyle, ½ grm;
Ext. of opium, 4 grs.;
Ext. of belladonna, 5 grs.;
Menthol, 10 grs.;
Vaseline, 1 oz.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 29th, 1905.

TUBERCULIN IN FEBRILE CASES.

In the further pursuit of his theory, Aufrecht laid before the Mercin Medical Meeting his latest experiments with tuberculin in the febrile state of tuberculosis which, he contends, is a proof of the hæmatogenous or vascular origin of tuberculosis. He commenced these cases with minimal doses of half a milligramme. He took five examples of high temperature in the pulmonary form and one in the peritoneal. In all, the tuberculin produced an improvement, which could only be said to be of a relative character, as the recurrency of the disease took place at different periods, till death finally ended their sufferings. In none of the cases was there complete normal temperature produced. Zupnick said that the fever by the use of tuberculin was sometimes reduced, as he had seen in two cases, although the high fever is reckoned to be a contra-indication for the use of tuberculin, yet as an antipyretic it proved very useful in these two cases. As a curative agent he could not support the contention, as it frequently failed, though several authors assure us they have had good results. His experience was equally disappointing in diphtheria antitoxin and tetanus antitoxin. Tuberculin was beyond our control, and a very inconstant medicament, doing more harm than good. Aufrecht agreed with much of Zupnick's experience as to tuberculin being a specific, and recommended quinine as the best drug for febrile conditions in tuberculosis.

FUNCTIONAL DIAGNOSIS IN PULMONARY DISEASES.

Winternitz raised a question of functional diagnosis by the use of the spirometer, and affirmed that the normal lung stood as 8–1, when comparing the pulmonary capacity with deep breathing. These conditions are altered when any equation appear in the pleural cavity or in the lung tissue itself. Change will produce a ratio of 6–1, or as low as 3–1.

DISEASE IN THE ILEOCÆCAL REGION.

Elbogen showed a few cases of intestinal disease. The first was a female, æt. 26, who had suffered for three years from constipation, flatulence, and pain in the ileocæcal region, where a swelling about the size of a man's fist, of irregular surface, was found. Laparotomy was performed, and the tumour found to be a thick, hard, dark hypertrophy of muscular tissue adhering to the peritoneum. A large perforation, about the size of a shilling, entered the tumour, which was filled with pus and fæces. Another opening was observed into the peritoneal cavity, though none of the contents had escaped. After careful separation of the bowel and resection of the adhering tumour, the patient recovered in ten days. The tumour when examined involved a portion of the ileum and ascending colon. The colon was found to be healthy, but the ilium and cæcum were composed of degenerative gland tissue adhering to the mesentery. The ileum contained a polypus, which had evidently sprung from the mucous membrane, producing a stenosis in the cæcum and final closure of the bowel.

The second was a female, æt. 43, who had always been healthy up to three months ago, when she took ill with sickness, vomiting, and pain in the lower part of the right side of the abdomen. When examined, a hard tumour about the size of a child's head was found immovably fixed in the iliac region. Laparotomy was performed, and the hard inflammatory mass involving ilium, cæcum, colon ascendens, and a part of the transverse colon was removed, which included sixty centimetres of the alimentary tract. The patient perfectly recovered in a month. On examining the part removed, the wall of the ileum and cæcum was found to contain tuberculin tissue, leaving only a lumen passage that would admit of a quill.

Operating Theatres.

ROYAL FREE HOSPITAL.

CHEILOPLASTY.—Mr. WILLMOTT EVANS operated on a man, æt. 34, whose upper lip had undergone almost complete destruction from gummatous ulceration. In the middle line was a small projection, as it were a continuation of the septum nasi, but laterally none of the lip remained. More than a year had elapsed since any ulceration had appeared, and during a great part of the time anti-syphilitic treatment had been continued. The patient was anæsthetised with chloroform; the situation of the opening of Stensen's duct was first made clear in order that it should not be wounded; Mr. Evans then cut a muco-cutaneous flap on the right side, comprising the whole thickness of the cheek; it was pear-shaped, and the attached stalk was about a quarter of an inch in width and arose just beyond the original angle of the mouth. This was in order to allow the flap to be turned inwards without undue tension. The greatest length of the flap was almost horizontal; a precisely similar flap was then cut from the left cheek. The lower border of what remained of the upper lip was then pared and the two cheek flaps were turned inwards and sutured together in the middle line and were also sutured to the remains of the upper lip. Mr. Evans took great care in uniting the mucous membrane of the new lip; the stitches employed were fine silk

The wounds caused by the raising of the cheek flaps were also united in the same manner. The cutaneous aspect of the wound was covered with gauze and collodion. The operation lasted over an hour. Mr. Evans said that there was always an element of doubt as to the advisability of performing plastic operations for the relief of deformities resulting from syphilitic ulceration, for the chance of the recurrence of the disease in the flaps was by no means small; but in this case a whole year had elapsed without any syphilitic signs, so Mr. Evans thought operation quite justifiable. So far as he was aware the plan he had employed of utilising the whole thickness of the cheek for the formation of the new upper lip was original. Its advantages he considered were (1) that the tendency to contraction afterwards was extremely small; (2) that it was comparatively easy to cut so large a flap as to render the new lip free from tension; (3) the portion of the moustache that remained could be utilised on the upper lip, and would help to hide the scar. He remarked that the importance of avoiding injury to Stensen's duct was obvious. Operations for the formation of a new upper lip were, he said, very rare. The employment of hare-lip pins was, in his opinion, not desirable as they often gave rise to unsightly scars, and it was easy to do without them. He laid great stress on the use of numerous fine silk sutures to ensure correct coaptation of the flaps, and especially was this advisable in the mucous aspect, where accurate adjustment of the edges of the wounds did much to prevent the risk of septic infection. The vascular supply of the face, he pointed out, was so plentiful that there was no risk of sloughing of the flaps.

The further progress of the case was in every way satisfactory. The stitches were removed on the tenth day, and the man left the hospital at the end of a fortnight. It was then decided to fit him with a set of artificial teeth for his upper jaw, and in order to allow a cast of the mouth to be taken it was found necessary to slightly enlarge the mouth at one angle, so as to permit a dentist's tray to be introduced. When seen six months after the operation, the upper lip showed no signs of contraction; a slight moustache had grown from the remnants of the original moustache on the flaps. The patient's general appearance was greatly improved, and the scars were not at all conspicuous; his articulation also was very much better than previous to operation, and no specific manifestations had appeared.

Conjoint Examination in Scotland.

The following candidates having passed the requisite examinations of the Conjoint Board, were admitted Diplomates in Public Health:—Harold Sherman Ballantyne, M.B., C.M., Eskbank; Lee Ferdinando Bianchi, M.R.C.P.E., Portobello; John Jardine, M.B., Ch.B., Penicuik; Philip Anthony Harry, M.B., Ch.B., Edinburgh; Richard Caldecott Monnington, M.B., Ch.B., Broughton-in-Furness; François Leon Keisler, L.R.C.P. and S.E., Edinburgh; Kenneth Andrew Moody-Stuart, M.B., Ch.B., Errol; Robert Abraham Logan van Someren, M.B., Ch.B., Edinburgh; Mohamed Ebrahim Sufi, L.R.C.P. and S.E., Edinburgh; Joseph William Sutton, L.R.C.P. and S.E., Newport; David Llewelyn Williams, F.R.C.S.E., Colwyn Bay; Robert Allan Cunningham, M.B., Ch.B., Co. Donegal; Alexander James MacGregor, M.D., Dunfermline; and George Wight, M.B., Ch.B., Grantshouse. At the same Sederunt the following gentlemen passed the First Examination in Public Health:—William Hamilton Simpson, M.B., Ch.B., New Zealand; David Robertson Dobie, M.D., Crieff; Jamshijd Dadabhai Munsiff, L.R.C.P. and S.E., Edinburgh, and Francis Edmund Larkins, M.B., Ch.B., Edinburgh.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 1, 1905.

PREVENTION OF DISEASE IN THE ARMY.

Ever since the exposure of the scandalous disregard of modern science which caused the death of thousands of British soldiers in South Africa, we have looked anxiously for signs that the War Office and military authorities had determined that no such slur on their intelligence and capacity should occur again. But we have failed to perceive any sufficiently reassuring ones. True, some enthusiastic officers in the Royal Army Medical Corps have been at work, reading, experimenting, and writing, and there is no doubt that they know, and are prepared to put into practice, those methods of disease-prevention which knowledge and experience have shown not only to be practicable, but even brilliantly successful where they have been adopted. The Royal Army Medical Corps, however, is a professional body—and is known to be more keenly alive to its duties and responsibilities to-day than ever in the past, but the initiation of large sanitary schemes and energetic hygienic measures rests not with them but with the wiseacres of Pall Mall, whose attitude towards such reform is pretty well characterised by Lord Wolseley's dictum that "medical advice is a very good thing, when it is asked for." The exponents of this policy cannot be made too strongly to feel that the Army is a national asset, and that it is for the nation to say whether or not its soldiers are to be immolated on the altar of official ineptitude and arrogance. It behoves, then, all organs of professional opinion to repeat, in season and out of season, even to the verge of wearisomeness, that the efficiency and health of the Army can be largely and profoundly affected by scientific means, and that till the last indications that hygienic teaching can give have been fulfilled, there can be no honourable rest for those responsible for the direction of the Army. In the meantime it can only be by the education of the public that its Ministers and servants can be made to realise what is required of them, and this education process has never proved a rapid one in the past, and is not likely to prove so in the present instance. An admirable summary of what can be done under skilled direction towards the protection of the soldier from disease was given in a paper presented by Major J. R. Kean at the annual meeting of the Association of Military Surgeons in America last month. This paper had gained the 500 dollar prize, offered by Major Seaman, and was an excellent digest of the most important considerations that should guide military preventive medicine. Major Kean began by showing the relative prevalence of different diseases in different armies, and demonstrated that all the military statistics for the armies of different countries except those for the Japanese—exhibited one common feature—namely, that whereas typhoid fever and bowel diseases constituted but a small fraction of the maladies of an army in barracks in peace time, yet when that same army took the field it was attacked by these complaints to an alarming extent. Moreover, it was in camp that these diseases became rife, an army on the march as a rule being comparatively immune. The armies of Kuroki and Oku, both of which consisted of enormous numbers, where approximate strength could only be vaguely ascertained, had during the Manchurian campaigns suffered singularly little from typhoid and dysentery, not two hundred in the case of Kuroki and only about five hundred in that of Oku. Now the Japanese soldier on the march, said Major Kean, is as careless as an American volunteer about safeguarding his water supply and regarding camp police, but on the other hand when he is in camp he is closely watched and made to obey sanitary regulations. Even away from active service conditions, typhoid can become widely prevalent in standing camps if management is lax and conducted on unscientific principles, a fact that was sadly manifested in the volunteer camps in the United States in 1898, when no less than 20,000 cases of typhoid with 2,000 deaths occurred under peace conditions. But in war, when soldiers are encamped on the same site for any length of time, the danger of bowel diseases—especially typhoid and dysentery—is and always has been very great. In the Franco-Prussian war 14,904 German soldiers died of disease, typhoid causing 60 per cent, and dysentery 16 per cent, of these deaths. Now it has been shown that these diseases are among the preventable ones, but it is equally certain that they cannot be prevented without extraordinary pains and organisation. Major Kean rightly attaches great importance to the disposal of excreta, and he lays special stress on the covering in of latrines, so that flies may be unable to gain access to them. He holds that each latrine should be roofed to keep out rain, and that each seat should be surmounted by a hinged flap to cover it when not in use. A bar should be so placed that the flap cannot be raised to a right angle, as by this means the flap prevents men squatting on the seat when in use, and automatically falls down after use. Moreover, dry earth or lime should be provided to cover all excreta passed. Major Kean recognises the practical difficulties of sterilising water but insists on its necessity, as also on the safeguarding of food from fly contamination. Tents should be moved every week and no camp occupied for more than a month at a time. If possible, all excreta should be eventually disposed of by burning. But adequately to carry out these measures, Major Kean remarks is a task which involves the co-operation of the whole army, and that it is therefore necessary not only to instruct the line officers, but to make them, in their turn, instruct the men under tneir command. The officers must recognise that the work of sanitation is a vital necessity; not a mere doctor's fad, but an essential condition in the fitness of an army. The whole of the sanitary supervision and direction must, however, lie in the hands of the medical department, which alone is composed of men acquainted with the real principles of action. Now it is just on this rock of medical control that the split occurs, for the military man likes to be supreme in his own province; but if our forces are to take the field without a repetition of the old disasters, personal feelings must be set aside in favour of the common good, and the sanitary circumstances of the army must be directed by the only men who are capable of directing them efficiently—namely, the doctors.

POLICE ADMINISTRATION AND THE MEDICAL PROFESSION.

The relation of the medical profession to the community at large is complex. It does not end, as many unthinking folk imagine, with the mere provision of skilled attention in case of disease of mind or body. Its functions, as a matter of fact, ramify throughout the whole body politic, and are concerned more or less directly with almost every branch of social life. It is impossible, for instance, to start any serious discussion of our educational or of our Poor-law systems, of the national birth-rate, of water supplies, of war, of plagues, of prostitution, of famine, or, in a word, of hardly a single great social topic that does not involve an appeal to medical authority, which not infrequently is called upon to utter the last word upon the subject in question. Among many important public problems that demand investigation and reform is the comparatively neglected field of the criminal administration of the United Kingdom. There are many points in which the aid of scientific medicine is required. One of the first and greatest is that of authoritative supervision of the mental condition of accused and convicted persons. Hardly a week passes without the scandal of the haranguing in a police court of some unfortunate person whose actions and speech present an unmistakable picture of mental irresponsibility. The many phases of police court insanity demand in the interests of justice adequate investigation and the provision of some means of automatic appeal and control. It took many years and hundreds of convictions before magistrates and police discovered that poor Jane Cakebread was insane. Yet many a time in the police court she paraded delusions sufficient to place her at once within the category of the mentally unsound. Then there is the case of the Birmingham lawyer, Edalji, sentenced to a long term of penal servitude for the senseless and purposeless maiming of cattle. The verdict was based upon circumstantial evidence of a flimsy nature. The outrages did not cease after the imprisonment of Edalji, and in one case another man confessed to having committed one of the offences. The ground taken up by the MEDICAL PRESS AND CIRCULAR, however, was that if an educated man of the prisoner's position maimed and killed cattle without rhyme or reason he must have been insane. On the strength of that dilemma, readers will remember, we presented a petition to the Home Secretary, praying for either the release of Edalji or his transference to a criminal lunatic asylum. This document was signed by a number of medical men, including some of the most distinguished alienist authorities in the Kingdom. No official action resulted at the time. A few weeks ago, however, it was announced that Edalji's sentence had been shortened by four years. What does that mean? Edalji is either guilty or innocent. If guilty, why shorten his sentence for what, supposing it to have been deliberately and responsibly carried out, constituted an atrocious series of crimes? If innocent, why keep him an hour longer in gaol? If insane and irresponsible, should he be turned loose on society? If the Government is convinced that the sentence on Edalji was wrong, then it should have the courage of its conviction, and add another to the already too frequent miscarriages of justice that have disgraced our criminal law administration in recent years. The Crown has doubtless obtained independent medical testimony as to the mental condition of Edalji, but so long as that is kept officially secret we see no reason to alter our deliberate conclusion that on simple medico-legal grounds the administration of justice has in this particular instance been defective. Many issues might be raised in other directions, but it will suffice here to mention one only. Last week, in Bury Police Court, Dr. Greenhalgh entered an emphatic protest against the way in which one of his patients had been haled out of bed at midnight and taken into gaol by the police. The man, he said, was unfit to go. It appears that this unfortunate citizen's offence was having fallen into arrears with his wife's maintenance order. He was clearly under medical care, and presumably, therefore, could have been arrested by the police at a reasonable hour of the day, instead of in the middle of a chill October night. The incident savours of a Russian secret police visit, with its cruelty and injustice, rather than of the orderly police administration of a free country. It is comforting to find that our medical men do not hesitate to protest against such harshness when they are called upon to protect the interests of sick persons. Supposing a prisoner were to die—as might readily happen—from the effects of arrest under such inexcusable circumstances as the foregoing, the police would be directly responsible for the result. It is to be hoped that the attention of Parliament will be called to the incident.

Notes on Current Topics.

Pharmacy and the Law.

AT a meeting of the Manchester Branch of the Pharmaceutical Society, the President of the society called attention again to the glaring anomaly presented by the drug companies which now flourish so widely throughout the country. Pharmacy legislation, like medical legislation, has always proceeded on the assumption of personal responsibility attaching to the individual, and this assumption has been the real safeguard of the public in their dealings with chemists and doctors. But by an extraordinary oversight in the drafting of the 1868 Pharmacy Act, it has been found possible for a body of unqualified persons to band themselves together—and by calling themselves a company to assume the title of chemists and druggists, which can only be obtained by an individual after due examination as to his fitness. The House of Lords, it was pointed out, had in their stupendous wisdom decided that what it was illegal for one person to do it was legal for a number of persons to do together. The plea of three drug companies that they employ qualified assistants furnishes no efficient protection of the public, as the intention of the Legislature was that the keeper of a pharmacist's business should himself be a chemist, with the privileges and responsibilities attached to that calling. It is interesting to learn that a private Bill is to be introduced into Parliament for the protection of the title of chemist, and we are sure that the pharmacists will have the support of the medical profession in attempting to pass it, as medical men themselves have been flouted in the same way by "Medical" companies and similar organisations which are a law unto themselves and responsible to nobody but their shareholders.

An Accomplished Graduate.

THE standard of medical and scholastic attainment required by some of the "out-west" medical colleges in America, is in marked contrast with that demanded in the Eastern States. From the correspondence columns of the *New Zealand Medical Journal* we gather some choice excerpts from the examination-papers of a graduate from one of these colleges who lately sat for a State Board examination. Asked to give the physical signs and symptoms of cerebro-spinal meningitis, he wrote: "Cerebro-spinal meningitis is inflammation of the spinal column or spinal coru, and of the Cerebelliam of the brain it is also Pain in the back and back of the head there is heat and inflammation." A question similarly couched as to tuberculosis of the lungs, evoked the reply: "Tuberculosis of the lungs is pain in the brest a dry and Hacking caugh, and may spit up some and they may no." Asked to name three respiratory stimulants and the diseases in which he would use them, he answered: "We have the wine, milk, and Soups, I would use them in Lagripp and Pneumonia." There are many other answers in a similar strain, which we have not space to give, but we cannot forbear presenting the following choice gem. Question: "Give Koch's postulates or rules in regard to bacterial cause of disease." Answer: "well the bacteria gets into the system and sets up an eritation and they jest keep accumilateing and become more and more all the time if the Patient is old they are harder to destroy if the patient old wore out and broke down when they once get hold they accumilate very readily they will live several days in the Sun they are the cause of many diseases." If a person of the high degree of culture that the answers suggest is entitled to dub himself M.D., one can only cease to wonder that quackery, homœopathy, osteopathy, and Christian Science flourish on the North American Continent. We fancy that we should become something very unorthodox if we lived in a State where gentlemen of the calibre of this one represented the regular practitioner.

Rye Bread in Diabetes.

A PRACTICAL suggestion of some merit is made in a short paper by Dr. Lidwell in the *Intercolonial Medical Journal* for August. The author, having received many complaints from his diabetic patients as to their diets, tried all the bread substitutes in turn—almond cakes, torrified bread, gluten bread, bran biscuits, and so on—but found objections to them all, both on the ground of palatability and price. One of his patients had a particular objection to bran biscuits, but made a bargain with Dr. Lidwell that he would continue to eat them if his dog would. The dog, a St. Bernard, who had not tasted food for twenty hours, was accordingly called in, and presented with a bran biscuit thickly buttered. The animal proceeded to lick the butter off, but absolutely refused to eat the tempting morsel itself. Few medical men have had quite such unfortunate experiences, but Dr. Lidwell was led by this and other circumstances to try rye-bread (pumpernickel),and found not only that it was liked by patients, but that it could be taken without causing any increase in the sugar in the urine. Questioning how a bread made from a flour that contained 73 per cent. of starch could be useful in diabetes, he ascertained first that a little rye-bread was very satisfying and therefore not much was eaten, and secondly by experiment *in vitro* that only 10 or 12 per cent. of the starch present was digested into dextrose and lævulose. He concluded, therefore, that owing to the resistance rye-bread presents to the digestive juices, it may safely be given in diabetes, and that it has the additional advantages of being both laxative to the bowels and cheap in price. The monotony of a strict diabetic diet is always a trying feature, and it is possible that rye-bread may be found on trial to be a safe and welcome addition to the ordinary fare.

Biological Treatment of Sewage.

THE disposal of sewage is one of the prime requisites of a civilised community, and it is not a little remarkable that at the present day there are still wide differences among experts as to what is the best system for rendering it innocuous. The biological treatment was at its initiation hailed as the final solution to the problem, but further experience has shown that the question is by no means a simple one. Every lot of sewage to be treated has to receive individual consideration as to its composition, rate of flow, and state of dilution No hard-and-fast method seems sufficient for every kind of sewage, and great personal care and sagacity are required to attain satisfactory results. Still, because of its cheapness, cleanness, and the satisfactory character of its effluent, the biological treatment promises to become the system of the future, and it is interesting to notice that the works of the Sutton (Surrey) Urban District Council, some of the first of their kind to be erected in the country, are working so successfully as to cause heartburnings among less fortunate authorities. Not only, however, is the system working well, but it is doing so at the exceedingly low cost of £2 3s. 11½d. per million gallons—the whole price paid last year for 217,580,000 gallons of sewage being only £478. Even this does not finish the story, for the Council initiated a plan for growing peppermint on their sewage-farms, and in 1905 obtained a crop from which they derived a profit of £145. These experiences are sufficiently rare to stimulate interest and emulation.

League of Pitiful Deliverance.

IT has been an object of desire with many people that a system for accomplishing euthanasia in hopeless and suffering patients should be established under State auspices. Whether the day will ever come in this country or no, a weird society, constituted to step in where the State fears to tread, has been formed in Siberia. This society calls itself the "League of Pitiful Deliverance," and has been secretly formed to put away the old and infirm relatives of its members. Private meetings are held and the persons to be killed are named and the members who are to remove them are given their commission. The existence of the society came to light through one person who was causing her friends inconvenience through an attack of rheumatism objecting to being delivered from her troubles by means pitiful or the reverse. She therefore adopted the prosaic course of informing the police, with the result that three brothers have been arrested and charged with conspiring to murder. In the meantime the work of the league remains in abeyance, and it appears likely that even in Siberia its continued existence will not be suffered by the authorities. The latter prefer keeping the prerogative of "pitiful deliverance" in their own hands.

New Colonial Medical School.

It has long been recognised by missionaries and other pioneers that, next to religion, medicine is the most potent of civilising agencies, but it is a little curious that in our large tropical colonies but little has hitherto been done to train natives to become doctors. In several colonies natives are trained to assist the European doctors, and these assistants often develop into practitioners on their own account, but a regular and thorough training has not hitherto seemed possible in many places. Following, however, the medical college in Hong Kong and that in Ceylon, comes a proposal to establish one in the Straits Settlements, which has obtained the approval of the Legislative Council and been commended to the Colonial Secretary. The funds are to be provided partly by grants from the Governments of the Straits Settlements and of the Federated Malay States, and partly by subscriptions, which latter, considering the interest evinced in the colony, should be forthcoming in good quantity. The College is to be managed by a President, who is to be the principal medical officer of the Colony, and a council, partly elected by subscribers and partly nominated. A full curriculum with lecturers in the various subjects is to be provided, and after qualifying examinations are passed a diploma is to be granted which will entitle the holder to be entered on the Medical Register of the Colony. It appears from the regulations that a high standard of knowledge is to be demanded, one of the conditions being that the majority of examiners are to be persons who are not engaged in teaching in the school. How this regulation is to be carried into effect we confess we do not understand, as most of the medical officers in the Colony must surely have lost touch with most of the elementary subjects of the curriculum, at least to such an extent as to make them unwilling to pit themselves as examiners against freshly-trained students. At any rate, there is good evidence that the school is to come into being, and we are sure that it will form a most important auxiliary to the administration of the uncomfortable lands that it serves.

Belief in Witchcraft.

Curious instances of folk-medicine and of belief in witchcraft or charms occasionally crop up in the remote country districts all through the Kingdom. A few days ago the Irish papers contained the report of the prosecution by the Crown of an old man near Galway on the charge of obtaining money for the performance of supposed cures to be wrought by charms. It appears that one patient had been treated by this "wise man," and had been told by him that his "lungs were melting away." The patient had to supply a loaf of bread and some butter, and in them the charm was set, directions being given that they were to be partaken of before breakfast. Unfortunately the patient did not give the charm time to try its power, as he committed suicide three days later. It the case of another patient, the "wise man" treated toothache by a charm similarly set in butter, and the toothache disappeared. The patient very ungratefully did not recognise the efficacy of the charm, but referred the cure to the will of God. Such incidents as these are by no means uncommon among country people not only in Ireland but elsewhere, but it is not often that they find their way into the law courts.

Electrocution.

Although execution by electric current has now been in use as the legal method in some of the American States for nearly twenty years, it has not yet passed beyond the stage of criticism. Some experiments recently carried out by Dr. Louise Robinswitch are likely to revive this criticism, and already some of the medical papers of America are directing attention to the subject. Dr. Robinswitch's experiments have been on rabbits, and she finds that the usual electric current in their case is as low as fourteen volts. The proportional voltage in man would be perhaps 200. More important than the lethal dose, however, is the fact that a very low voltage—five—was sufficient to cause complete loss of consciousness. Resuscitation was attempted in many cases, and was successful when radial pulse, heart-beat, or muscular movements were present, but failed in their absence. State electrocution in New York is always carried out with currents of high voltage, and is stated in some cases not to have attained the desired end. Muscular contractions and cardiac movements have been observed after the application of the current, and it has even been alleged that the real execution took place in the *post-mortem* chamber at the touch of the pathologist's knife, and not in the electric chair. Moreover, witnesses of electrocutions are by no means agreed that death by electric shock of high voltage is painless. If Dr. Robinswitch's results are confirmed, it would appear to be advisable to substitute a current of lower voltage for that now in official use in the States.

The Midwives Act and District Nursing.

In one of his works Mr. Charles Booth, the well-known writer on social matters, remarks that "of all the forms that charity takes, there is hardly one that is so directly successful as district nursing." With this opinion most medical men in general practice will agree. It is difficult indeed to estimate not merely the physical relief and comfort given to the sufferer by the ministrations of a skilful nurse, but also the educating influence brought into the homes of the poor by her visitations. Medical men all over the country have been glad to avail themselves of the services of the district nurse, and have shown their confidence in this form of charity by their active support. It is generally recognised, indeed, that without the confidence of the medical profession, district nursing work would be either impossible or injurious, and the promoters of district nursing movements have uniformly made it their first object to enlist—an easy task—the support of the medical men of the neighbourhood. One of the unfortunate results of the passing of the Midwives Act is that this good feeling between medical men and district nurses is likely, in some districts at least, to be disturbed. One of the fundamental rules of most district nursing associations is that the nurse shall only act in conjunction with a doctor, unless in cases of grave emergency. It is now proposed, in some places, for instance in the Cumberland Nursing Association, to delete this rule, since it may prevent registered midwives from enjoying the right to practise secured them by law. It is sincerely to be hoped that this change will not be made, as it would open the door to many abuses. If a district nurse is to practise midwifery as an independent practitioner it will be very difficult to restrict her activities from medical and surgical affairs. It will, moreover, undoubtedly rouse the legitimate hostility of general practitioners and interfere with the present successful work of the district nurse

The Strenuous Life.

The President of the United States has lately been taken to task for urging his subjects to increase the strenuousness of their lives, but we fancy that most medical men who are acquainted with Trans-Atlantic manners will agree that a little pause and time for reflection would probably be of more benefit to the race than an increase of exertion. The *Boston Medical and Surgical Journal* has lately reproduced some statistics culled from a New York daily which gives a vivid idea of the pace at which the Western hemisphere rotates. According to these calculations a child is born in New York every six minutes, and a funeral takes place every seven minutes. A quarter of the population die of tuberculosis, so that this disease claims a victim every twenty-eight minutes. A fatal accident occurs once every hour and three-quarters, and something like two persons commit suicide every day. Murder is perpetrated every two days, and an attempt to kill is made every eight hours. Every thirteen minutes two people are joined in wedlock, and about one in twenty of the happy couples so joined find solace in divorce. An immigrant arrives in New York every forty seconds, and a building is erected every fifty-one minutes. Two hundred and twelve letters are written every minute; an arrest is made every ten minutes; and a "drunk" is run-in every ten minutes. A new law suit is entered every ten seconds, and a new lawyer is qualified every twelve hours to cope with the mass of litigation thus produced. More than one train enters the city every minute, and more than one vessel leaves the harbour every hour. Reading these bewildering statements of what we presume to be facts, we can only appeal to the shade of Christopher Columbus to witness whether a course of Weir-Mitchell treatment is not now urgently required for the American nation than any increase in the strenuousness of its life.

A Medical Library for India.

A movement is on foot among the officers of the Indian Medical Service to urge on the Government the necessity of providing, at a convenient centre, a comprehensive medical library. At present there is practically no library of any use to medical men throughout the length and breadth of India. It is true that in the District-General's office at Simla there is a fair library, rather miscellaneous in character, but the books are merely works of reference for the use of the District-General himself, and cannot be made available to individual workers throughout the Empire. In the Medical Colleges of Calcutta, Bombay, Madras, and Lahore there are, of course, also useful collections of books available for the staff and students of the college. The present proposal is that a central medical library well furnished with books of reference and current periodicals should be established in charge of a skilled librarian. In addition to the library of reference, there should be a circulating library with several copies of the best modern books on medicine, surgery, and the allied sciences. These books should be available on easy terms to officers throughout India. A model for such a library is that established within the last few years at Manila for the use of United States employees in the Philippines. Started in 1905 with a nucleus of fifty volumes, it contained a few months ago over seventeen thousand. Access to such a library does much to keep tropical workers interested and instructed, and we have no hesitation in urging that a similar institution should be established in India.

The International Congress of Medicine, Lisbon, 1906.

There is every reason to hope that the fifteenth meeting of the International Congress of Medicine, which is to be held at Lisbon from the 19th to 26th April, 1906, will be as pleasant and as well-managed as the Paris Congress. We understand that the Executive Committee, guided by its energetic secretary, Prof. Miguel Bombarda, is taking every precaution to overcome the difficulties which reduced the Madrid meeting to a state of chaos. One of the chief difficulties in the matter of the Lisbon Congress is the accommodation of visitors, because the really first-rate hotels in the city are very few. The National Committee for Great Britain and Ireland have therefore made a wise departure. They have approached Messrs. Thomas Cook and Son with a view to chartering a vessel which should convey the British members to Lisbon, serve them as an hotel during the Congress and bring them back again to London as soon as it is over. Messrs. Cook and Son now announce that they have obtained the s.s. *Ophir* for this purpose. The boat is well-known for its large size and first-rate passenger accommodation, and it was the vessel in which T.R.H. the Prince and Princess of Wales made their voyage to Australia. It is proposed that the *Ophir* shall leave London on the afternoon of Thursday, April 12th, the day before Good Friday, and return to London early on the morning of Monday, April 30th. The fares are fixed at 15 to 35 guineas per person, according to the position of the cabin, including food and free communication at frequent intervals between the ship and the shore. Whilst the vessel lies in the Tagus the harbour authorities have allotted her the berth lately given to the Royal Yacht when H.M. the Queen with H.R.H. Princess Victoria visited Lisbon. This berth is about 500 yards from the shore in deep water, and with a rapid stream. It is hoped that the employment of the s.s. *Ophir* will obviate the necessity of making arrangements for lodging in Lisbon, as passengers will be able to retain their cabins and meals will be served at regular hours. The *Ophir* will proceed to Tangier and Gibraltar and will touch at Vigo. The British colony at Oporto is especially anxious to show some civility to the members of the Congress and arrangements are therefore being made to stay at least one day at Leixoes either in going or returning. It is hoped that early application will be made for berths on the s.s. *Ophir*, as the accommodation is necessarily limited and must be allotted in rotation. The honorary secretaries are Mr. D'Arcy Power, 10A, Chandos Street, Cavendish Square, and Dr. Clive Riviere, 19, Devonshire Street, W.

Radical Changes in London Medical Schools.

Amalgamation and reconstruction are the orders of the day among certain of the more progressive of the London Medical schools. For instance, under arrangements made with the Westminster Hospital Medical School, the students have been transferred to King's College for their preliminary and intermediate medical studies; and under arrangements made by the University of London with University and King's Colleges, a number of the students of St. George's Hospital Medical School have also entered King's College for the same purpose. The students will, on the completion of their intermediate course, return to their own medical schools for their advanced studies. In order to assist the University in this beginning, the concentration of the earlier medical studies, the Council of King's College has spent a considerable sum of money during the long vacation in extending and further equipping the laboratories. The rapid growth of the provincial schools, where degrees can be obtained upon easy terms, has greatly weakened the position of the metropolis in medical education. In spite of an incomparable wealth of clinical material, it has been the aim of the London teachers to turn out men with a sort of temporary encyclopædic information derived from books and lectures. This method fails to provide the student with the essential weapons with which in after life he must win and hold his footing in general practice.

Datas, the Mnemonic Prodigy.

Those of our readers who have witnessed the memory feats of the man Datas will bear ready testimony to their phenomenal nature. In his case the faculty of memory seems to have reached an extraordinary pitch of development, so that he can give an instant answer as to names, dates, places, and other details that bear upon subjects covering an encyclopædic range. In some ways his gift may be compared with that of great musical performers and of chess-players who can play a score of games blindfold, or of other mnemonic sports. Often these extraordinary special endowments go with intellects that are, generally speaking, of a moderate level. In the case of Datas there appears to be an exceptional development of brain, which is estimated to weigh seventy ounces. Originally a gas-stoker in London, he has turned his natural gift to such purpose that he is now making upon the stage the income of a cabinet minister. An American professor, so it is reported, has signed and sealed a contract with Datas to purchase his brain for £2,000, the organ to be claimed after death. It is hardly likely that the interests of science will be advanced by any scientific examination of the organ in question. In this country, by the way, such a bargain would not be binding upon the friends of Datas after his decease.

Some Aspects of the Lunacy Question in Ireland.

The very marked increase which has taken place during the last decade in the numbers of the certified insane, and is still continuing, has served to attract the attention of both the medical profession and the public. So important do the Lunacy Commissioners consider the question that they have asked for a special report on the subject from each Resident Superintendent in Ireland, and these reports will shortly appear in the Annual Report of the Commissioners. We have also thought it well to focus the attention of our readers on the subject, and to this end have arranged for the publication of a series of articles from the pens of prominent members of the lunacy service. In this series such subjects as the increase of lunacy in Ireland, and its causes; the family treatment of the insane, the management of auxiliary asylums, the treatment of lunatics in workhouses, and the duties of the general practitioner in lunacy cases will be fully considered. The contributors to the series include such eminent alienists as Dr. Drapes, of Enniscorthy; Dr. Connolly Norman, of Dublin; Dr. Nolan, of Down; Dr. Mills, of Ballinasloe; and Dr. Donelan, of Portrane. The entire series will prove of much interest and value, not alone to members of the lunacy service, but also to medical men generally. The first article from the pen of Dr. Nolan, of Down, appears in our issue of to-day.

The Shut Railway-Carriage Window.

Everyone knows the railway traveller who insists upon keeping the carriage-window shut. Seated grimly in a corner, he holds the key to the position, so far as his own window is concerned. It requires some strength of character, however, for a traveller to rise from a centre seat and shut or open a window in the teeth of opposition from the corner seats. Indeed, it speaks volumes for the imperturbable good-nature of the British traveller that disputes do not occur more often over railway-carriage windows. From the medical point of view there is a good deal to be said. A person susceptible to cold is risking a more or less certain attack of rheum and catarrh by facing an open window on his journey. Why should he suffer, so much at the whim of his fellow-passenger of the middle seats? The latter, however, has a strong case from the hygienic point of view. It has been shown times out of number that ordinary railway carriages are simply saturated with harmful germs of many kinds, and the less pure the air of the compartment the more rampant the microbes. In other words, ventilation is absolutely necessary for the wholesomeness of a railway carriage, especially when we take into consideration its cramped and confined space. Half a dozen occupants are enough to pollute so small a volume of air in a short quarter of an hour. Fresh air, therefore, must be admitted by ventilation. To trust to an open window for that purpose is like using a stone axe as a fighting weapon in place of a breech-loading rifle. The real bed-rock of the whole matter is that the railway companies have hitherto failed to furnish their railway carriages with a simple automatic and draught-avoiding ventilator. In another generation or so our descendants will have ceased to squabble over the railway-carriage window, and, let us hope, over many other abuses of environment, such as quack medicines, tight corsets, unqualified medical practice, sewage-polluted drinking-water, and other rocks ahead known to medical pilots.

Proposed Alterations of the "British Medical Journal."

A somewhat noteworthy resolution was passed at the last meeting of the Council of the British Medical Association:—"(1) That the size of the page of the *Journal* be altered to 162 brevier lines of 19 ems 12 to pica leaded; (2) that in addition the *Journal* be issued with a grey-tinted cover; (3) that the scale of charges for advertisements be revised by the manager in order to increase the price to £8 per page" Thus, on the strength of this resolution, the members of the Association will understand that in the course of time—it is not stated when—their accredited organ will appear in a vastly different dress. The idea of making use of a grey-tinted cover is entirely novel as applied to the *Journal*, and may possibly lead to some criticism. The "covers" of journals, of course are mainly useful for adding to the advertisement revenue of which the publications become the source; it is for no cosmetic reasons that their employment is so frequently resorted to. The last clause, however, in the resolution, which refers to the increase in the advertisement rates, is perhaps the most important of all. This means, if the clause is carried into effect, that advertisers will have to pay about 50 per cent. more for their announcements than has hitherto obtained. The *Journal*, therefore, as an advertising medium will be the most costly among all the organs which now appeal to the profession. Under this new arrangement it will be interesting to observe how the advertisers will respond. They are, as a class, a fickle community; the proposed change may or may not commend itself to them. Possibly the more wealthy houses will continue their patronage as hitherto; on the other hand, the increased price is bound to affect many of the smaller firms, by whom the struggle in the competition for business is mostly felt. Then, furthermore, there are the members of the Association themselves to be taken into account—we refer to those who advertise their publications. The higher rates would undoubtedly press heavily upon them. A special clause should have been introduced, excluding the members of the Association who advertise from being called upon to pay more than the usual rates. In our opinion, it is too often overlooked that, after all, the *British Medical Journal* belongs to the members of the Association, and not to the few officials who for the time being have been elected to carry on its business. A common idea prevails that when a member politely presumes upon his supposed privileges as a member he is treated with scant courtesy; on the other hand, if he shows fight, offers the "powers that be" a single ticket to a place *not scheduled by the railway companies*, and indicates his intention of paying them a personal visit, then he is likely to be treated with as much decorum as the office to the Association can command. But all this may be mere coffee-house babble.

PERSONAL.

Mr. J. E. S. Frazer, F.R.C.S., has been transferred from St. George's Hospital, London, to King's College as demonstrator in anatomy.

Colonel C. M. Royds, C.B., M.P., and his wife have presented at a cost of £2,000 a new drill hall to the St. John Ambulance Corps of Rochdale, which has a membership of nearly two hundred. The popular parliamentary representative of the borough opened the building recently in the presence of a large gathering.

The Senate of the Royal University of Ireland have conferred the honorary degree of M.Ch. on Mr. J. S. McArdle, Surgeon to St. Vincent's Hospital, Dublin, in recognition of his contributions to surgery.

Dr. Andrew Horne has been appointed to represent the Royal Academy of Medicine in Ireland on a Special Committee nominated to consider the advisability of adopting a fixed standard by which to estimate the character of the puerperium.

Dr. William Alexander Osborne, M.B., B.Ch., D.Sc., Professor of Physiology and Histology in the University of Melbourne, has been nominated by the Senate of London University to be their representative at the jubilee celebrations of that university in April, 1906.

Dr. Philip Henry Pye Smith, M.D., B.A., F.R.S., has been reappointed as the representative of London University on the General Medical Council.

The members of the County of Durham Medical Union last week made a handsome presentation to Dr. Edward Jepson, J.P., of Durham, president of the union from 1898 to 1905 The presentation articles were a very valuable roller-top desk and book-case for Dr. Jepson, and a handsome silver tea service to Mrs. Jepson.

A marriage has been arranged between Hugh Percy Dunn, F.R.C.S., of Wimpole-street, Cavendish Square, ophthalmic surgeon to the West London Hospital, and Marian Sara Georgina, only daughter of Mr. J. C. H. Flood, of the Middle Temple, barrister-at-law.

The Regius Professor of Medicine at Oxford, Dr. Wm. Osler, on the 26th ult., distributed the prizes to the successful students of the medical wing of University College, Bristol. Mr. Lewis Fry (chairman of the Council) presided.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

Proposed Treatment of Consumption at the City Hospital, Edinburgh.—The Public Health Committee of the Town Council have under consideration a report by Sir Henry Littlejohn, in which it is recommended that one scarlet fever pavilion in the fever hospital should be set apart for necessitous cases of phthisis. The annual mortality from this disease has decreased from 1.81 per mille in 1900 to 1.22 per mille in 1904, the diminution being due to improved sanitation, destruction of slum property, and better lighting and ventilation. The Parish Council have already opened wards in connection with Craiglockhart Poorhouse Hospital, and it is now suggested that the town should make similar provision, for advanced cases of phthisis occurring in a class which, though removed from pauperism, is often able to make both ends meet with the greatest difficulty. The proposed accommodation would suffice for fifty cases, and to set it apart for a year would serve as a guide to the future policy of the Council without in any way crippling the resources of the hospital so far as other infectious diseases are concerned. A necessary corollary to any such action would seem to be the compulsory notification of phthisis. The Public Health Committee have sent the report to the Town Council with the recommendation that it be adopted. The Municipal Elections are now approaching, and reference to the scheme has been made at several meetings. Edinburgh is hampered with a considerable debt sunk in unremunerative undertakings, and there is a very general desire that the rates should not be allowed to increase. There is no doubt that to open a ward for the treatment of advanced phthisis would mean the permanent addition of just so many inmates to the hospital for infectious diseases, with a corresponding permanent increase of cost, and it is a question whether, when all the spending departments of the Council are being urged to reduce their estimates, this extra expenditure will be faced.

Opening of the Winter Session at Edinburgh University.—The various medical classes were opened on the 17th ult. In nearly all cases the work for the session was immediately entered upon, as the custom of delivering an introductory lecture is year by year falling more into desuetude. Owing to the fact that he was appointed only on the 16th, Sir Halliday Croom did not open the class of midwifery until the 23rd ultimo, when he gave an inaugural address in the McEwan Hall. He was accompanied to the platform by Principal Sir William Turner, who introduced the new professor in a word, and numerous members of the Senatus. Sir Halliday Croom paid a tribute to the memory of Sir James Simpson, whose pupil he had been, and to Professor A. R. Simpson, and then discussed the advances made in obstetrics and gynæcology during the past half century.

The Managers of the Royal Infirmary on October 23rd appointed Dr. A. H. H. Sinclair to be assistant ophthalmic surgeon for a period of five years, in succession to Dr. W. G. Sym, promoted to be full surgeon on the resignation of Dr. George Berry.

University College, Dundee.—The annual report, issued on the 23rd ult., states that the great advance in the number of students made last session has been more than maintained, the matriculation for the year being 211. The past session is memorable in several respects: the new School of Medicine, the enlarged chemistry department, the new library, have all come into operation; the botanic garden has been doubled in size, the Students' Union has added materially to the comforts and amenities of undergraduate life. A considerable part of the report deals with the circumstances under which Dr. J. K. Caird's offer to build a new physics laboratory was withdrawn—in consequence of the vastness of the proposed structure , the unsuitability of the accommodation, and the cost which its completion would entail on the College.

GLASGOW.

Faults of Memory.—The first meeting of the Glasgow University Medico-Chirurgical Society for the present session was held on Friday last, when Dr. W. K. Hunter, D.Sc., M.D., delivered an address on "Faults of Memory." The lecturer first gave a description of the cells in which the memory for the various subjects was located, such as the motor and sensory cells, those for articulation, languages and hearing. He showed the development of memory in the babe, and that therefore it was a slow and arduous task for him to learn to walk. He had to develop the memory cells necessary for the use of the muscles required in walking, and as often as this memory failed he had a fall. The lecturer went on to speak about loss of memory in grown up people, which seemed to be sometimes caused by the fusion of the cells of different divisions of memory cells. He gave instances where two personalities had been developed in the same individual, the one personality having no recollection of the other one. Dr. Hunter also mentioned the different ways in which students imbibed knowledge most freely; some kept spoken words best in their memory, while others remembered best when they could quietly read from a book, and therefore the benefit these students derived from lectures was mostly by learning the notes which they had taken. The question was raised at the close whether, taking into account what the lecturer had said in regard to the right members of the body being used in the more intricate functions, such as the hand in writing, we might not develop more power by exercising our left members also. The gentleman who raised the question mentioned that the Japanese were ambidextrous. Dr. Hunter, in reply, said that what was wanted was quality more than quantity, and that by developing the left side of the body we would only add quantity to our already numerous faculties while we would in no way add to their quality. A vote of thanks was afterwards accorded Dr. Hunter for his lecture.

COMMEMORATION OF A FORMER GLASGOW UNIVERSITY PROFESSOR.—It has just been settled by the University Court, Senate and General Council that the name of Francis Hutcheson, who was Professor of Moral Philosophy from 1730 to 1746, should be commemorated on April 18th, 1906. At a service in the Bute Hall, Professor Henry Jones will give the Francis Hutcheson address, and in the evening there will be a dinner. When Professor Hutcheson held the chair of Moral Philosophy, he lectured five days a week on natural religion, morals, jurisprudence, and government, and three days a week upon the Greek and Latin moralists.

BELFAST.

OPENING OF WINTER SESSION.—Dr. John Morrow delivered the inaugural lecture at the opening of the medical session at the Royal Victoria Hospital, on Tuesday, October 24th. A large number of medical men, as well as students, were present, Dr. Morrow took as his subject "Our Profession and its Study." After welcoming the new students he dwelt on the question of over crowding, attributing the failures in the profession either to an absolute want of natural aptitude or a culpable want of diligence. In dealing with the work of the student he laid special emphasis on the necessity for extensive and painstaking clinical work, and most of all case-taking. At the conclusion of the address a vote of thanks to Dr. Morrow was moved by the chairman of the Medical Staff, Dr. J. Walton Browne, seconded by Sir William Whitla, and passed.

ULSTER BRANCH OF THE MEDICAL TEMPERANCE ASSOCIATION.—A meeting of this Branch was held in the Medical Institute, Belfast, on Friday afternoon, October 27th, the president, Dr. Charles Kevin, in the chair. An interesting discussion on the Treatment of Pneumonia without Alcohol was opened by Dr. William Calwell, President of the Ulster Medical Society. He dwelt first on the great change from the old times which has come over professional opinion on this subject. It is not so long since a pint of stimulant a day was advised by high authorities, then the frequent use of small quantities regularly came into vogue, and now many advised its use only in emergency. Dr. Calwell held that the generally accepted signs of benefit derived from alcohol were very fallacious—such signs as fuller pulse and slight flushing, and the sensations of the patient. No attention was paid to remoter effects, such as negative chemio-taxis, and the influence on the development of opsonines. In conclusion Dr. Calwell gave notes of a large number of his cases, showing that he had treated them with gradually lessening amounts of alcohol. and of late years often with none at all, and with apparently good results.

Correspondence.

THE SURGICAL CURE OF CONSTIPATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As I understand Mr. A. Lane's operation, he transfers the distal end of the ileum to the sigmoid, thus leaving the cæcum and transverse colon out of their natural place and functions in the stream or river of organic life. When I reflect on the exquisite corelations and interdependance of all the organs and parts of the body, I can only exclaim with Dominie Sampson, in presence of Mr. Lane's operation, "Pro-di-ge-ous!"

I can hardly believe that such an operation is called for. Constipation can be remedied by gentle persevering methods and habits. And, besides, constipation is not so serious a matter as to call for a capital surgical operation.

From forty to fifty years ago, when I went as Surgeon-Superintendent of Government Emigrants to Australia, a very great proportion of the young women would come, when about from two to four weeks out, and some even six weeks, saying that they had had no action of the bowels since sailing. I never knew, in hundreds of such cases, any harm to result.

With old people, we often find that the bowels do not usually act for many days, no harm resulting.

Personally, though naturally costive, I have not taken an aperient for fifty years. In an easterly cold wind I always get costive, but I never fail to get relief. In India I learnt to retire after breakfast, whether the sensation existed or not, lit my pipe, and relief would come. I have continued this practice with success. I am as happy as a kid before breakfast, but at once after breakfast my whole system, body and mind, is irritable till the action takes place. I have established a "habit" which is imperative.

I dine at 7 p.m., one course with vegetables and fruit, am an abstainer from alcohol. I always give a good rub over the abdomen night and morning, and drink half a tumbler of water with lime or lemon juice at bedtime. Like a Hindu or Moslem, I never use a seat but assume the natural attitude for defæcation.

Biologically, I shrink from so greatly excluding the functions of the cæcum and colon; and I hope my little personal experiences may not be without value.

I am, Sir, yours truly,

SENEX.

October 19th, 1905.

AN UNFAIR PARTING SHOT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I hope you will allow me to correct the false impression which must have been made upon those who read a short paragraph in last week's MEDICAL PRESS dealing with a body known as the "Parliamentary Association for the Abolition of Vivisection." This Association, which retired from the British Union (the late Miss Cobbe's society) last December, shows a not very commendable spirit in first making an absurd statement in its report, no doubt calculated to injure the Society from which it seceded, and then getting the same inserted in the press. The statement to which I refer is that the Association retired from the British Union "on account of the unbusinesslike way in which the managers of the Union were conducting its affairs." The real reason was simply that the head Society, when it took up its position in London, considering that its own committee were naturally responsible for its parliamentary work, refused to sanction the complete independence of the Parliamentary Association to which it allowed very full representation on that Committee. This was not only decided on grounds of policy, but in accordance with the strongly-expressed wish of the late Miss Cobbe. The word "unbusinesslike" would be better applied to the scheme rejected by the British Union, whereby a party which would have had great power on the Central Board, would have run an irresponsible and, financially, a rival society which traded under the name of the Union. The failure of a legal action recently brought by the leading member of the Parliamentary Association against the British Union gives corroborative evidence of the unassailable businesslike character of the latter.

I am, Sir, yours truly,

B. E. KIDD,

October 16th. Secretary, British Union,

32, Charing Cross.

THE UNIVERSITY OF OXFORD AND MEDICINE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It will be rather interesting to see whether the School of Medicine at Oxford will develop or not under the new Professor. Some years ago, although there were Professors at Oxford of medicine and the various subjects included in it, there was very little work done by the students. They waited till they came to London before they did any work of any value to them. There is no doubt but that Oxford has not much sympathy with Science of any kind: Metaphysics, not Physics, are more congenial to it, and the study of the past rather than the scrutiny of the future. It may be well, perhaps, that this is so. As Science, however, is coming rapidly to the front—and what the world owes to it is being more and more realised, and how poor those countries are which neglect it—Oxford would do well to consider what is best to do, if it wishes to keep up its reputation as a great University.

I am, Sir, yours truly,
Prospiciens.

Obituary.

LUCY HELEN ALEXANDER, L.R.C.P.I.& M.

Dr. Lucy Alexander, one of the medical officers connected with the Liverpool Medical Missionary Society, recently died as the result of a very painful accident. While at dinner on the night before her death, she swallowed a fishbone, and, failing to extract it by ordinary means, she was removed to the Royal Southern Hospital, where she underwent an operation. This was followed by her death as stated. Dr. Lucy Alexander, whose family resides in Dublin, came to the Medical Mission in Liverpool about two years ago. She won the esteem of her colleagues and the affection of many patients. She studied in Dublin, where she qualified medically in 1903.

JOHN MacDOWAL SMITH, M.D.Glasg., D.P.H., PERTH.

The death of Dr. John MacDowal Smith occurred at Cheltenham on the 9th ult., after a lingering illness. Dr. Smith was born at Perth in 1856, and proceeded to Glasgow University, where he graduated in 1879. Since then he had been in private practice on his own account, first in the parish of Cramond, then in West Calder, Dundonald, Ayrshire, and latterly at Cheltenham, England. In 1891 he received the degree of M.D. from his alma mater, with honours, the subject of his thesis being "The Disposal of Sewage and City Refuse." The drawing of Sir Wm. Gairdner, which appeared in the Jubilee Book (1901) of the University of Glasgow, was from his pencil. Dr. Smith leaves a widow, a son, and a daughter to mourn his loss.

ROBERT SOMERVILLE, M.D.Ed., F.R.C.S.Ed., J.P., OF GALASHIELS.

By the death of Dr. Robert Somerville, which took place on the 9th ult., Galashiels has lost its oldest medical practitioner, and one of its most prominent citizens. Dr. Somerville succeeded to the practice of the late Dr. M'Dougall in 1852. Dr. Somerville found time to take an active part in the public business of the town, and was one of the first Police Commissioners appointed. It was, however, in connection with educational affairs that Dr. Somerville, who was a recognised authority on the question, was best known. In the Baptist denomination Dr. Somerville was senior deacon of Stirling Street Baptist Church, and also for one year occupied the president's chair of the Baptist Union of Scotland. He also served for a term as president of the Edinburgh Harveian Society. Dr. Somerville was 69 years of age, and is survived by his widow and three sons and three daughters.

ERNEST FIELD, M.D.Aberd., M.R.C.S., L.R.C.P. Lond.

We regret to announce the death of Dr. Ernest Field. The circumstances are sad in the extreme. Dr. Field only lost his wife twelve months ago, and his own demise leaves as orphans four sons, three of whom are still at college; the eldest is studying medicine at Bristol. Dr. Field's health began to fail in June, but he had been seriously ill for the last two months only. The deceased gentleman was one of the many medical practitioners of the city who originally came to Bath as resident medical officers in 1874 at the Royal United Hospital. When the honorary medical staff was created, Dr. Field was appointed one of the honorary medical officers, and after giving unremitting attention to the patients, he resigned in 1889. Dr. Field, who was only 54 years of age, when a younger man made many contributions to the medical press.

WILLIAM JONES MORRIS, M.R.C.S.Eng., L.R.C.P.Ed.

Dr. William Jones Morris, of Portmadoc, died on the 15th ult. in London, where he had recently undergone a serious surgical operation. The deceased was one of the most popular figures in public life in North Wales. After a course of study at Liverpool Institute, he proceeded to the Anderson College Medical School, Glasgow, eventually qualifying as M.R.C.S. and L.R.C.P. After serving for some time on the staff of the Liverpool Dispensaries, he opened in Portmadoc and developed a remarkably successful practice. He threw himself heart and soul into public life, particularly in the education sphere. He was secretary of the North Wales branch of the British Medical Association, and in one year held office as president. Other appointments included surgeon-major in the 3rd Volunteer Battalion Royal Welsh Fusiliers and medical officer for Portmadoc District under the Festiniog Union.

T. H. PASSMORE, M.R.C.S.Eng.

The death took place suddenly on the 12th ult., at his residence, Lyndhurst, 6, Warleigh Road, Brighton, of Mr. T. H. Passmore, M.R.C.S. Having retired from professional life, Mr. Passmore had resided in Brighton for the past twenty years, during which period he had gathered around him a wide circle of friends. In his early days he held an appointment at Grenada Island, West Indies. Returning to England, he became medical officer of health for Dulwich, and upon his retirement made Brighton his home.

Literature.

BIDWELL ON INTESTINAL SURGERY. (a)

This little work contains a most interesting and clearly written description of the technique and common operative procedures of intestinal surgery. Commencing with a chapter devoted to general considerations on intestinal anastomosis, the necessary instruments, suture materials, &c., it proceeds to discuss the different methods of closing an incised wound of the bowel, lateral anastomosis, and end-to-end anastomosis. Operations on the stomach next receive attention, and a short description is given of Roux' method of performing gastro-enterostomy, but the author is inclined to condemn this operation on the ground that it is too severe. Chapters V. and VI. deal with operations on the large and small intestines such as enterostomy, colotomy, operations for the relief of intussusception and the management of an artificial anus. The remaining chapters deal with operations on the appendix, the different incisions of the abdominal wall and the methods of closing them, the necessary preparations before abdominal operations and the treatment afterwards.

The author very rightly considers that the proper closure of the abdominal wound is a matter of the greatest importance, and we thoroughly endorse his statement that "the method of uniting all the structures of each edge with one or two silkworm gut sutures should never be employed unless the patient is practically moribund." We do not see the advantage offered by the use of the mattress suture in stitching the peritoneum; in our opinion, a continuous suture is equally efficacious, and takes half the time or less. On the other hand, we have a high opinion of the value of mattress suture, in bringing together the fascia of the rectus muscle. It is better than a continuous suture for obvious reasons—which do not hold good in the case of the peritoneum, and it is better than a simple interrupted suture because it brings areas of the fascia of considerable size into contact and not merely opposing points.

(a) "A Handbook of Intestinal Surgery." By Leonard Bidwell, F.R.C.S., Surgeon, West London Hospital; Lecturer on Intestinal Surgery, &c., &c. Pp. XI. and 167. With 91 illustrations in the text. London: Bailliere, Tindall and Cox. 1905. Price 6s.

The book is admirably illustrated by some ninety illustrations in the text and these are both clearly drawn and *a propos*. The type and paper are alike good and the little work is most creditable to both publishers and author.

CURGENVEN ON THE CHILD'S DIET. (*a*)

THE author of this booklet has observed, as we all have, that children even of the upper educated classes are badly fed. He has written it chiefly for the use of his own patients. Bearing this fact in mind we wonder at such expressions as "adenoid growths in the naso-pharynx" (p. 44), and "glycogen" (p. 50), which are, in our opinion, much too scientific for a work such as this. In the index the word "mucous" occurs, which of course is intended for "mucus." Apart from this the directions given for feeding are sound and practical, while the treatment of constipation and of acute and chronic gastric catarrh is very clearly indicated. A number of recipes are appended, but we do not quite appreciate the introduction of those which we are told have been reprinted from a certain manufacturing company's cookery book, nor of those which introduce a certain much advertised food. If these had been left out there would have been little fault to find with what is undoubtedly a carefully written and accurate handbook.

LEWIS ON THE MANAGEMENT OF DELICATE CHILDREN. (*b*)

THIS little volume of some 200 pages, printed in large type, is an attempt to indicate the principles underlying the modification of a child's environment with a view to the improvement of the latter. The author discusses the general causes of delicacy, and gives a brief account of the various debilitating diseases to which children are liable, with their special treatment. Appended to the volume is a series of exercises destined to strengthen and develop those who are suffering from debility. There is a curious use of the word "corporeal" (which occurs twice on p. 63) for "corporal." This, however, is quite a minor point, for on the whole this *brochure* is well worthy of being carefully perused. It perhaps contains little that is novel, and yet it brings together a number of useful facts and suggestions for treatment with which every practitioner should make himself thoroughly acquainted.

DRINK RESTRICTION. (*c*)

THIS monograph forms Part VI. of Professor von Noorden's now celebrated series of treatises on disorders of metabolism, and well sustains the authors' previous reputation for ability in research, for clearness of therapeutical ideas, and for lucidity of exposition. It commences with an historical review of the subject of restriction of fluids in various diseases, in which the authors show that the idea is in no way new, but that it dates back as far as the time of Hippocrates, who was the first to advocate a limitation of both solid and liquid ingesta for patients suffering from cardiac disease. From the time of Hippocrates up to that of Tuffnell, many isolated clinicians employed similar therapeutical means, but it was not till the appearance of Oertel's work on cardio-vascular disorders that the profession as a whole became alive to the value of the 'thirst cure.' Oertel's scheme of treatment, however, was founded, as the authors point out, on insufficient or rather imperfect physiological data, for it has been shown conclusively that a hydræmic plethora does not exist in most cases of failing heart. The value of his treatment must therefore be regarded as depending on the fact that it (1) limits the recurring transportation of large quantities of liquid through the blood stream, and (2) limits the diffusion of water into the tissues, which diffusion must, by compression of capillaries, increase the resistance of the blood stream. The authors add that they are now accustomed to advise all sufferers from heart disease to limit their total fluid consumption to about two and a half pints daily.

With the object of determining the *rationale* of the thirst cure in obesity, the authors next proceed to investigate Oertel's second assumption, that restriction of fluids leads to an increased oxidation of the tissues. They first point out that a diminution of total fluid intake below about two pints per diem may prove dangerous owing to an insufficient elimination of nitrogenous waste products, and then go on to quote several of their own experiments which show (1) that there is no increase of oxidation of the tissues during a period of thirst; and (2) that an increase of nitrogenous output is generally observed during such a period. They, however, found that as a rule patients voluntarily eat less when their drink is restricted, and to this fact, as well as to the drying of the tissues which takes place, they attribute the loss of weight observed in all individuals when carrying out a thirst-cure.

Their conclusions are as follows:—When fluid is restricted (1) the stomach is relieved of much work and the pressure upon its walls is reduced; (2) the total work of the circulatory apparatus is decreased; (3) the fluids of the body become more concentrated; (4) the body weight is decreased; (5) the appetite is reduced; (6) the destruction of albumin is increased; (7) there is no increase in destruction of fat. We strongly recommend the work to all physicians and physiologists who wish to get a better insight into some of the more intricate processes of metabolism.

BURNET ON DISEASES OF CHILDREN. (*a*)

THE author laments only too truly that the knowledge of the diseases of infancy has in the past been too much neglected by the student and general practitioner in this country; and to remedy this the present volume is placed before the profession for the benefit of those who are beginning to study this subject of such vast import to the community. With this object in view, theoretical discussions have been avoided, "and even the morbid anatomy of the various diseases referred to will be found conspicuous by its absence. The latter omission is intentional, as we believe that the various morbid changes can only be studied to advantage in the *post-mortem* room." Altogether a most creditable and satisfactory volume is before us well calculated to achieve the purpose of laying "a good foundation for further reading and observation on the subjects of which it treats."

If we may be permitted to pick out a chapter for special comment we should like to refer our readers to that on "Infant Feeding." Feeling as we do that the welfare of the infant portion of our land depends chiefly on the feeding, and knowing that practitioners in times past have not been as well informed on this subject as they might have been, it is gratifying to find that the majority, keenly anxious to serve their country are paying especial attention to this problem, and so playing a most patriotic part, although perhaps sometimes a thankless one. This concise and

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(*a*) "The Child's Diet." By J. Sadler Curgenven, M.R.C.S.,L.R.C.P. London: H. K. Lewis. 1905. 1s. 6d.

(*b*) "The Care and Management of Delicate Children." By Dr. Percy Lewis, Honorary Medical Officer to the Victoria Hospital, and Surgeon to St. Andrew's Convalescent Home, Folkestone, &c. London: Cassell and Co., Ltd. 1905.

(*c*) "Drink Restriction (Thirst Cures) particularly in Obesity: being Part VI. of several Clinical Treatises on the Pathology and Therapy of Disorders of Metabolism and Nutrition." By Professor Carl von Noorden and Dr. Hugo Solomon. Translation by Boardman Reed, M.D., Philadelphia. Bristol: John Wright and Co. 1905.

(*a*) "Manual of Diseases of Children." By James Burnet, M.A., M.B., M.R.C.P.Edin., Registrar and Assistant to the Extra Physicians, Royal Hospital for Sick Children, Edinburgh. Pp. 406, with 8 plates and 10 illustrations and temperature charts. Edinburgh: E. & S. Livingstone. 1905. 6s. 6d. net.

most valuable chapter will, we are certain, be welcomed by the hardworked practitioner as a change from the deluge of patent food pamphlets showered on him by kindly manufacturers. We do not expect to agree with all the author says, for there is room for a wide divergence of opinion in this matter, but the recommendations are backed up by such commonsense arguments that we are sure that Dr. Burnet has rightly valued the subject and made a most careful study of it. We notice that the author takes exception to some patent foods because they dispense altogether with the use of fresh milk, and considers that they are only suitable as *temporary* expedients. This is only too true, and we have thus the choice of two evils—either risk milk containing objectionable organisms or else diminish its anti-scorbutic properties and sterilise it. One feels sorry for the poor child whose mother either can't or won't suckle it.

We agree that cod-liver oil is usually given in too large a quantity at a time, and also that emulsions of petroleum are not absorbed and are useless except as lubricants. We must commend the plates as likely to be very useful, also the chapters devoted to affections of the ear, throat, nose, eye and skin, which as we are reminded in the preface, "are, generally speaking, often misunderstood, or at least badly treated." We most heartily commend this book and are convinced that its true value will be highly appreciated by those who are realising their deficiency of knowledge of the subject.

HEALTH IN THE TROPICS. (*a*)

This book is written in a simple and popular manner in the hope that those who have to reside in the Tropics for short or long periods may benefit by its perusal. This modest hope will, we are certain, be more than fulfilled, as there is no possibility of even lay persons being unable to understand the advice given, and this advice is of the best. After reading through the book one is inclined to follow the immortal Oliver Twist and ask for more, as we are confident that the author could with advantage have written a larger book. As it is, however, each page is pregnant with most valuable information put in the most compact manner. Personal precautions, diet, drinking water, dwelling houses, and those illnesses that a traveller must ever be prepared for, are treated of in turn, and experience of tropical climates enables the reviewer to say with confidence that the book is a most suitable one. The preliminary precautions as to avoiding exposure to the sun and chill, may seem to a man who is just going out almost superfluous, but the amount of life sacrificed by the neglect of these simple details is notorious. Many men need an attack of sunstroke or fever as mentor to make them careful. Many little details are given which may seem trivial, but they are not on this account to be neglected, or unpleasant consequences may ensue. We trust that our readers will recommend this book to people journeying to tropical climates, as by doing so they will be doing a good turn to their friends or clients.

PRACTICE OF GYNÆCOLOGY. (*b*)

We agree with Dr. Ashton's statement in the preface to his "Practice of Gynæcology" that there should be a place for a treatise on this subject which gives directions and illustrations so explicit that they may be intelligently and easily followed, and we do not associate ourselves with those critics who, he fears, will reproach him with leaving nothing to the imagination or common-sense of his readers. Gynæcology is notoriously badly taught on this side of the Atlantic, and such teaching as there is is mostly theoretical. It is not too much to say that the bulk of students pass into practice with little personal acquaintance with women's diseases, and absolutely no skill in the technique of gynæcological manipulations. In Dr. Ashton's book they will not find any great literary charm, nor is it replete with pathological learning; but they will find the most elaborate and minute illustrations of each step in every procedure that the gynæcologist is called upon to perform. To a man taking up general practice or to one lately appointed to a hospital staff, this book will be found of great practical help, guiding him through every difficulty and piloting him through all the storms and billows of gynæcology, billows which too often buffet him sadly. There has been a distinct tendency of late years towards the production by American teachers of books of the type of the one before us—books of an essentially practical type, in which only so much of the theory of a subject is introduced as will lead to the adequate comprehension of the directions for treatment, these latter being given with great care and in great detail. Such books we fancy, answer a modern demand on the part of the practitioner. This sorely-tried individual does his best to keep abreast of his rapidly-developing science, but a point comes when he feels he can keep pace no longer; then he turns, and says, "Tell me what to do for my patient, and only so much of latter-day theorising as I can follow and enjoy." Dr. Ashton's book precisely caters for this class. The illustrations make no pretence to artistic merit, but they are without exception the most accurate and exhaustive series of diagrams we have met with, and armed with them no practitioner need fear embarking on any procedure in the realm of gynæcology, from making a bimanual examination to performing an ovariotomy—without adequately comprehending every manipulative detail. Ourselves, we are inclined to criticise the disproportionate amount of the work occupied by surgical affections and operations, but perhaps this is significant of "gynæcology" as it now is, rather than of "women's diseases," as they once were. The book, as a whole, deserves warm commendation, and we shall be much surprised if it does not soon reach many editions. It strikes an English reviewer as somewhat quaint that a book on this subject—which professes to "leave nothing to the imagination," should be dedicated to the author's wife; the fact that it is so supplies an interesting comment on the cleavage of the Anglo-Saxon race.

SCHULTZE ON TOPOGRAPHIC ANATOMY (*a*.)

Those who were already acquainted with Professor Schultze's "Applied Anatomy" in its German edition, will be glad to welcome this American translation of his work, for the book undoubtedly fills a gap. As the author himself states, the book is written not for the anatomist, but for him who wishes to become a physician and as he goes on to say that "no claim is made for anatomic completeness," or even for completeness in those details that are of importance, to the physician we can hardly complain of the brevity of his text. The whole of anatomy is in fact dealt with in 171 octavo pages of rather large print, but within that space the author manages to compress all the bigger facts. The application of these facts, however, appears to be dealt with in an unnecessarily meagre manner, and we think that some additions in this respect might with advantage have been made and incorporated in the text by the present editor. The very short editorial additions, that have been made are enclosed in brackets at the ends of the paragraphs to which they belong, and while not adding anything of importance to the subject-matter, tend to mar the beauty of the page.

(*a*) "The Maintenance of Health in the Tropics." By W. J. Simpson, M.D., F.R.C.P., Professor of Hygiene, King's College, and Lecturer on Tropical Hygiene at the London School of Tropical Medicine. Crown 8vo. Price 2s. 6d. net. Illustrated. Pp. 118. London: John Bale, Sons, and Danielssohn, Ltd. 1905.

(*b*) "A Text Book on the Practice of Gynæcology for Practitioners and Students." By William Easterly Ashton, M.D., LL.D., Professor of Gynæcology in the Medico-Chirurgical College, and Gynæcologist to the Medico-Chirurgical Hospital, Philadelphia. With 1,046 new drawings. Philadelphia: W. B. Saunders and Co. 1905. Price 27s. 6d.

(*a*) "Atlas and Text Book of Topographic and Applied Anatomy. By Oskar Schultze. Translated by George D. Stewart, M.D. Philadelphia: W. B. Saunders and Co. 1905.

and interfere with the continuity of the text. This is, however, a small matter, and the very absence of detail will probably make the book more acceptable to practitioners who have become rather rusty in their anatomical knowledge, for it is to that class that we believe the book to be suited rather than to the medical student just fresh from his work in the dissecting room. The very beautiful plates and illustrations, 114 in number, form the most characteristic feature of the book. Most of these are from original preparations, while a few, and by no means the best, are taken from his well-known models. So complete indeed is the series of illustrations that a study of them renders almost unnecessary any descriptive text, and one feels sure on looking at them that the author must have felt tempted to reduce his work to an Atlas alone. The artists and the printers are to be congratulated on the execution and the colouring, the latter especially appearing to us to be superior to anything that we have previously seen. On the whole the work may be stated to occupy a position midway between the large text-books of anatomy, and the large works on surgical and applied anatomy, which already exist, and as such we can cordially recommend it to the general practitioner.

HOMŒOPATHY EXPLAINED. (*a*)

This small octavo of xx-212 pages gives an account of the genesis of the therapeutic theory and practice of Hahnemann, written by an ardent admirer of the noted medical heresiarch. Dr. Clarke's devotion is all the more single-minded and uncompromising from the fact that he is a convert from the older faith. And having regard to the latter fact, it is very understandable that he should elect to devote the first of the twenty-four chapters into which he has divided his text to the autobiographical account of "How I Became a Homœopath." A case of "a crop of warts" had the epoch-making effect. The excrescences had resisted the diligent treatment by the "family doctor." They all disappeared in the space of three weeks under the influence of *thiya occidentalis*.

April 10th of the present year marked the 150th anniversary of the birth of the founder of homœopathy. It is interesting to know that the original Greek word, in its adjective application occurs twice in the New Testament (Acts xiv. 15; James v. 17), and that one of the inspired writers who uses it is the physician, St. Luke. Dr. Clarke points out, with a relishing chuckle that "So far as I am aware, there is no Scripture for allopathy." The various chapters of this little volume form clear and easy reading, and introduce some interesting and gossipy information regarding the foundations of the salient articles of homœopathic faith. We have found them quite entertaining. We offer no detailed criticism or allopathic argument, as we feel that it is more than unlikely that Dr. Clarke or ourselves would ever convince the other.

OPERATIVE OPHTHALMOLOGY (*b*).

The Medical Hand-Atlases are, we hope, too well-known to require any special recommendation from us, so that when we say that Dr. Haab's "Operative Ophthalmology" is a worthy member of the series, we have said enough to let every ophthalmic surgeon know that it is an indispensable adjunct to his library. Dr. Haab himself has already written two admirable monographs in the Hand-Atlas series, namely those on the External Diseases of the Eye, and on Ophthalmoscopy and Ophthalmoscopic Diagnosis, and though there may be fewer practitioners to whom the present volume will directly appeal, there will be none already possessed of the former volumes who will be disappointed in this third one. Not the least valuable part of the book is the first section, entitled "General Considerations," especially the chapter on Sterilisation in Antisepsis. Dr. Haab has not been content to take the word of others in the matter of disinfecting technique, and the results at which he has arrived are those which commend themselves as being in accordance both with scientific knowledge and common-sense. Early in the field of antiseptic enquiry, Dr. Haab, while still an assistant, began studying bacteriology in spite of the jeers of his contemporaries, and proceeded even to Edinburgh to watch Lister and learn his methods. Returning home Dr. Haab applied the master's teaching to his first operation in 1878, and was sufficiently encouraged by his results to pursue his methods to their logical extreme. His triumph came when he was able to show a first series of 400 cataracts with a percentage of .25 of failure from suppuration, and subsequently 540 with a percentage of .37 from the same cause. In this book Dr. Haab gives not only the opinions he has arrived at as the result of his long experience, but the views of others on important questions, and the whole work lacks little to make a complete treatise on the subject. The coloured lithographs with which to the number of thirty, the book is illustrated, are choice specimens of their kind; we have seen nothing better; they are life-like to a startling degree. It is impossible to conceive of anything more vivid than the plates illustrating the cataract-operations and iridectomy; one can almost measure the depth of anterior chamber in them. A word of praise is due to Dr. de Schweinitz for having rendered the work into pleasant, flowing English.

DIETETICS FOR NURSES. (*a*).

We have read Dr. Friedenwald's and Ruhrah's "Dietetics for Nurses" with much interest and much enjoyment. The authors seem as nearly as possible to have hit that happy mean between verbiage and platitudinarianism which is so difficult to attain in a short book on a well-worn subject. The style is pleasant and succinct, but nearly always graceful and the interest seldom flags. Naturally, in a book of this kind the didactic standpoint is maintained, but not offensively so, for where possible credit is given to special authorities or divergence of views allowed. But in the main the orthodox line is followed, and it needs great skill to prevent the orthodox in dietetics from degenerating into the hum-drum. We are sorry that the authors after explaining the drawbacks of sterilised milk for infants should (p. 109) apparently give their sanction to its use as a routine practice in warm weather, unless an "exceptionally" pure milk can be obtained. Also that they should recommend the preparation of the child's twenty-four hour supply of milk at one fell swoop. "Exceptionally" pure milk may be difficult to obtain; pure milk need not be, and pure fresh milk is the ideal diet for a child when the mother's milk fails. Moreover, there are but few places where milk cannot be obtained at least twice a day. In our opinion, the directions for the preparation of milk for artificially-fed infants are rather too complicated for the ordinary nurse, and indeed we are rather struck all through the book by the fact that the American nurse must be subjected to a higher course of preliminary training than her British cousin, if she is to grasp all the points set before her in this manual. Still no nurse can study it without adding largely to her usefulness and resource, and to medical students it can be confidently recommended. We may go further, and say that the practitioner who has this book at his elbow will be able smilingly to face the most anxious mother and the most fastidious patient, conscious of a superiority in his knowledge of what should be eaten and drunk by the healthy and sick.

(*a*) "Homœopathy Explained." By John Henry Clarke, M.D. London: Homœopathic Publishing Co. 1905.

(*b*) "Atlas and Epitome of Operative Ophthalmology." By Professor Haab. Edited by G. E. de Schweinitz, A.M., M.D., Professor of Ophthalmology in the University of Pennsylvania. With 30 coloured lithographic plates, and 154 text-cuts. Philadelphia: W. B. Saunders and Co. 1905. 15s. net.

(*a*) "Dietetics for Nurses." By Julius Friedenwald, M.D., and John Ruhrah, M.D., Clinical Professors in the College of Physicians and Surgeons, Baltimore. Philadelphia: W. B. Saunders and Co. 1905. 6s. 6d. net.

The new edition of Ellis's "Demonstrations of Anatomy" upon which Dr. Christopher Addison has been engaged for some time past will be published by Messrs. Smith, Elder and Co. this week. The matter has been altogether re-arranged, and it now follows the ordinary course of dissection as followed by students New illustrations have been added, many of them, together with several of the old ones, being reproduced in colours, and a good deal of new matter has been introduced, especially in the parts dealing with the viscera.

NEW BOOKS AND NEW EDITIONS.

The following have been received since the publication of our last list :—

Sidney Appleton (London).
- The Diseases of Infancy and Childhood. By L. E. Holt, M.D., &c., &c. Third Edition. Revised and Enlarged. Illustrated. Pp. 1174. Price 25s. net.
- The Diagnostics of Internal Medicine. By G. R. Butler, Sc.D., M.D. Second Revised Edition. Illustrated. Pp. 1168. Price 25s. net.

Bailliere, Tindall and Cox (London).
- Military Hygiene. By Robert Caldwell, F.R.C.S., D.P.H., Lieut.-Colonel, R.A.M.C. Illustrated. Pp. 416. Price 10s. 6d. net.
- The Nature and Treatment of Cancer. By John A. Shaw-Mackenzie, M.D. Second Edition. Revised and Enlarged. Pp. 91. Price 2s. 6d. net.
- Nodal Fever. By Alfred Austin Lendon, M.D.Lond. Illustrated. Pp. 90. Price 5s. net.

David Bryce and Son (Glasgow).
- A System of Surgical Nursing. By A. N. M'Gregor, M.D., &c. Pp. 554. Price 9s. net.

Cassell and Co.,Ltd. (London.)
- Materia Medica and Therapeutics. By J. Mitchell Bruce, M.A., LL.D., M.D. New Edition. Pp. 632. Price 7s. 6d.
- Organotherapy or Treatment by Means of Preparation of Various Organs. By H. Batty Shaw, M.D. Illustrated. Pp. 256. Price 6s.

J. and A. Churchill (London).
- A Text-Book of Materia Medica for Students of Medicine. By C. R. Marshall, M.D. Pp. 635. Price 10s. 6d. net.

Wm. Green and Sons (Edinburgh).
- Methods of Morbid Histology and Clinical Pathology. By J. Walker Hall, M.D., and G. Herxhiemier, M.D. Pp. 290. Price 9s. net.

Charles Griffin and Co., Ltd. (London).
- A Medical and Surgical Help for Shipmasters and Officers in the Merchant Navy. By W. J. Smith, F.R.C.S. Third Edition. Revised. Illustrated. Pp. 349. Price 6s.

H. K. Lewis (London).
- A Guide to the Administration of Ethyl Chloride. By G. A. H. Barton, M.D. Pp. 36. Price 1s. 6d.
- The Theory and Practice of Medicine. 2 Vols. By Frederick T. Roberts, M.D., &c., &c. Tenth Edition. Pp. 1368. Price 26s. net.

J. B. Lippincott Co. (London).
- Therapeutics: its Principles and Practice. By H. C. Wood, M.D., LL.D. Twelfth Edition. Revised. Pp. 907. Price 18s. net.
- The Principles of Clinical Pathology. By Dr. Rudolf Krehl. Translated from the Third German Edition. By A. W. Hewlett, M.D. with Introduction by Wm. Osler, M.D. Pp. 504. Price 21s. net

Longmans, Green and Co. (London).
- The Diseases of Children: Medical and Surgical. By Henry Ashby. M.D., &c., and G. A. Wright, B.A., M.B., &c. Fifth Edition. Revised. Pp. 920. Price 21s. net.
- Anatomy, Descriptive and Surgical. By Henry Gray, F.R.S. Sixteenth Edition. Edited by T. Pickering Pick, F.R.C.S., and Robert Howden, M.A., M.B., &c. Pp. 1248. Price 32s. net.
- Hygiene. By J. Lane Notter, M.A., M.D., and R. H. Firth. Sixth Edition. Pp. 491. Price 4s. 6d.
- The Food Factor in Disease. 2 Vols. By Francis Hare, M.D. Pp. 1032. Price 30s. net.

Macmillan and Co., Ltd. (London).
- The Prevention of Senility, and a Sanitary Outlook. By Sir James Crichton-Browne, M.D., &c., &c. Pp. 141. Price 2s. 6d. net.
- Handbook of Physiology for Students and Practitioners of Medicine. By Austin Flint, M.D., LL.D. Illustrated. Pp. 877. Price 21s. net.

The "Pall Mall" Press (London).
- The Doctor and the Simpler Life. By C. W. Saleeby, M.D. Pp. 95. Price 1s.

John Wright and Co. (Bristol).
- Golden Rules of Sick Nursing. By W. B. Drummond, M.B., &c., &c. Pp. 97. Price 1s.

The Scientific Press, Ltd. (London).
- Medical Electricity and Light Treatment. By Kate Neal. Pp. 98. Price 2s. 6d. net.
- The Nursing of Sick Children. By James Burnet, M.A., M.D., &c. Pp. 66. Price 1s. net.
- Nursing: Hints to Probationers on Practical Work. By Mary H. Annesley Voysey. Pp. 111. Price 2s. net.

It is announced that the London Asylums Board manufactures its own serum. The production of antitoxin serum for diphtheria patients by the Metropolitan Asylums Board has proved a great success, and the cost has been reduced from 10d. to 6½d. a dose.

Medical News.

Glasgow Obstetrical and Gynæcological Society.

The following is a list of office-bearers for Session 1905-1906: Hon. President, Dr. C. J. Cullingworth (London); President, Dr. J. K. Kelly; Vice-Presidents, Dr. John Lindsay and Dr. A. W. Russell; Treasurer, Dr. G. N. Turner; Secretary, Dr. G. Balfour Marshall; Editor of Transactions, Dr. A. N. M'Lellan; Reporting Secretary, Dr. A. Louise M'Ilroy. Pathologist, Dr. John H. Teacher; Past President, Dr. J. Nigel Stark. Additional Members of Council: Dr. R. O. Adamson, Dr. W. L. Reid, Dr. David Watson, Dr. Campbell Syme, Dr. William Ritchie, Dr. James Craig.

Glasgow Medico-Chirurgical Society.

The following is a list of office-bearers for Session, 1905-1906:—President, Dr. J. Lindsay Steven; Vice-Presidents, Dr. J. Walker Downie and Dr. W. K. Hunter. Council.—Section of Medicine: Dr. Donald Mackintosh, Dr. Cowan, Dr. Norman M'Nair, Dr. Wm. Grant. Section of Surgery: Dr. Peter Paterson, Dr. G. Burnside Buchanan, Dr. Jas. Lawrie. Section of Pathology: Professor Muir, Dr. Joshua Ferguson, Dr. Leslie Buchanan. Section of Obstetrics: Dr. M'Bride, Dr. David Watson, Dr. Robert Jardine, Dr. Samuel J. Cameron. Treasurer, Dr. Alfred A. Young, 2, Woodside Terrace. Editorial Secretary, Dr. Jas. Scott, 11, Hillend Gardens. Hyndland Road. General Secretary, Dr. Archibald Young, 34, Berkeley Terrace.

Experts in Typhoid Epidemics.

At the next meeting of the Society of Medical Officers of Health, Dr. Christopher Childs will read a paper entitled "A comparative Study of the Lincoln, Maidstone, and Worthing Epidemics," and will bring forward the following proposition:—"In case of a typhoid epidemic it is necessary to have in reserve a staff of experts who will be prepared, if called in by the local Medical Officer of Health, to go at once to the locality invaded to co-operate with and under him; to assist in tracing out the source and channels of infection, and in detecting incubating, ambulant, and abortive cases; and to investigate all circumstances of the epidemic which may throw light upon the etiology of this disease."

Beri-Beri on a British Ship.

A Chinaman, who was employed on the steamer Heathburn, has been landed at Hartlepool, suffering from beri-beri. He was admitted to the port sanitary hospital and isolated. Five other Chinese employed on the same vessel were seized with the malady, but they have recovered.

Royal College of Physicians of London.

At the ordinary quarterly comitia held on Thursday last, October 26th, the following gentlemen, having passed the required examinations, were admitted to the membership:—A. G. Gibson, B.A., M.B.Oxf., St. Thomas's Hospital; J. G. Harsant, M.D.Lond., Guys' Hospital; E. B. Leech, M.A., M.B.Camb., L.R.C.P., Manchester; J. C. H. Leicester, M.D.Lond., L.R.C.P., captain I.M.S., of Univ. Coll., London.

Conjoint Examinations in Ireland.

Third Professional Examination.—Candidates who have passed this examination are:—P. Blake, H. Burbidge, C. M. Burton, G. H. Caldwell, H. C. Carden, P. J. Cusack, J. D'Alton, P. G. M. Elvery, E. H. F. Gilligan, J. B. Hanafin, R. B. Herrick, E. M. Loughnan, F. J. Morris, J. Molyneux, P. J. Murray, C. F. Murphy, D. M'Cormack, J. M. O'Connell, W. R. O'Farrell, H. J. Raverty, T. Sheehy, and R. Stephens. Copies of the regulations for the preliminary examinations to be held during the year 1906, can be obtained on application.

The Senate of London University has decided on the addition of tropical medicine as a sixth branch of the examination for the degrees of M.D. In this branch there will be three papers—an essay, a clinical examination, and a laboratory examination. The complete regulations will be published shortly.

Notices to Correspondents, &c.

☛ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Oxoniensis.—Most surgeons are willing to meet homœopathic practitioners in consultation. Most physicians decline to meet homœopaths, but there are various exceptions amongst leading men. The Royal College of Physicians of London does not countenance the practice. It may be argued that the rule which guides surgeons in this matter should also apply to physicians. The decision may be left to the individual practitioner. If he can find enough wheat in the bushel of chaff that constitutes Hahnemannism past and present, by all means let him meet the disciples of that curious sect, if he have a mind to do so.

THE WINE INDUSTRY.

Mr. Gilbey in his annual report and summary to *The Times* gives some statistics of the remarkable vintage of 1904, which, both in regard to quantity and quality, far exceeded the most sanguine anticipations formed. The magnitude of this industry will probably astonish some of our readers when they learn that last year's production on the Continent alone reached the extraordinary aggregate of three thousand five hundred million gallons, a quantity one million gallons in excess of 1903, but France herself according to the corrected official figures, produced no less than two hundred and fifty million gallons beyond the estimate; her vineyards with those of Algeria producing together the prodigious total of one thousand, six hundred and twenty-six million gallons of wine.

J. L. Much (Yorks).—The remedy is largely used in France, but its composition is secret. It is said to contain an alkaloid of opium. In any case it is undesirable for medical men to prescribe that or any other remedy of whose precise nature they are ignorant.

LONDON PUBLIC HEALTH AND VITAL STATISTICS.

Daily, during 1904, about two hundred and fifty million gallons of sewage arrived at the L.C.C.'s two outfalls and were chemically treated. The designers of the system of London's drainage had much under-estimated the growth of population, and the Council, face to face with the necessity for large extensions, has decided to carry out work, including a scheme of flood relief, estimated to cost over four and a half millions, of which about £370,000 was expended during the year under review. In the matter of food inspection the Chairman spoke of the desirability of doing away with private slaughter-houses in London.

E. M. S. (Chertsey).—The fault probably lay in the defective spectacles supplied by the optician in the first instance. In a difficult case of compound astigmatism it is impossible to gauge the condition accurately without the use of mydriatics. So far, we believe that the sight testing optician, in his triumphant progress from the counter of the shop, to the consulting room, has not hitherto ventured to use medicaments to the eye. The practice, however, has been seriously advocated by some of these bogus practitioners. Your patient's prolonged astigmatic headaches doubtless arise from badly prescribed spectacles, and would have been prevented by timely advice from an experienced ophthalmic surgeon.

ARMY MEDICAL SERVICE.

Official notice is given that an examination of candidates for no less than 40 Commissions in the Royal Army Medical Corps will be held on January 26th, 1906 and following days.

Erratum.—In Dr. Mapother's letter in last issue the word "correct" is printed instead of "incorrect."

Meetings of the Societies, Lectures, &c.

Wednesday, November 1st.

Ostetrical Society of London (20, Hanover Square, W.).—8 p.m. Specimens will be shown. Short communication:—Mr. C. N. Longridge: Case of Eclampsia. Paper:—Mr. A. Doran: Subtotal Hysterectomy for Fibroids, After-Histories of 60 Cases, Preservation of Ovary and the Abel-Zweifel Theor.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. P. Paton: Clinique. (Surgical.) 5.15 p.m. Dr. H. Tilley: The Diagnosis and Treatment of Nasal and Post-Nasal Catarrh.

Post-Graduate College (West London Hospital, Hammersmith Road, W).—5 p.m. Dr. Beddard: Practical Medicine.

North-East London Post-Graduate College (North-Eastern Fever Hospital, St. Ann's Road, N.).—2.30 p.m. Dr. F. M. Turner: Demonstration on Fevers.

Hospital for Consumption and Diseases of the Chest (Brompton).—4 p.m.—Dr. Habershon: Clinical Lecture on Cases in the Wards.

University College, London (Gower Street, W.C.).—Clinical Lecture:—Dr. Poynton: Arthritis (with lantern demonstration).

Thursday, November 2nd.

North-East London Clinical Society (Tottenham Hospital, N.)—4. p.m. Address:—Mr. A. W. Mayo Robson: Common Duct Cholelithiasis, Symptoms, Complications, and Treatment.

Röntgen Society (20 Hanover Square, W.).—8.15 p.m. Paper:—Prof. Wertheim-Salomonson (Amsterdam): The Ruhmkorff Coil.

Childhood Society and the British Child-Study Association (Parkes Museum, Margaret St., W.).—8 p.m. Lecture:—Prof. E. Barnes: A Quantitative Study—Children's Attitude towards History, (Arranged by the British Child-Study Association.

Medical Graduates' College and Polyclinic, (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. A. H. Tubby: Surgical Disease of Children.

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Edwards: Vesical Stone.

St. John's Hospital for Diseases of the Skin (Leicester Square W.C.).—6 p.m. Dr. M. Dockrell: The Solution of the Confusion between Pityriasis Rubra, Pilaris, and Lichen, and the Treatment of each. (Chesterfield Lecture).

Mount Vernon Hospital for Consumption and Diseases of the Chest (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. G. Johnston: Prognosis in Phthisis. (Post-Graduate Course).

Friday, November 3rd.

West London Medico-Chirurgical Society (West London Hospital, Hammersmith, W.).—8 p.m. Clinical Meeting.

Laryngological Society of London (Hanover Square, W.).—5 p.m. Cases and Specimens will be shown by Mr. de Santi, Dr. Kelson, Dr. Potter, Sir Felix Semon, and others.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. H. Tilley: Clinique. (Throat.)

Post-Graduate College (West London Hospital, Hammersmith Road W.).—5 p.m. Mr. Baldwin: Practical Surgery.

Vacancies.

Leeds General Infirmary.—Laboratory Curator. Salary £200 per annum. Applications to Thomas Blair, General Manager.

Bristol Royal Infirmary.—House Surgeon. Salary £100 a year, with apartments, board and laundry. Applications to W. E. Bodgett, Secretary and House Governor.

Nottingham General Hospital.—House Surgeon. Salary £100 a year, with board, lodging, and washing. Applications to E. M. Keely Secretary.

Hackney Union.—Second Assistant Medical Officer at the Workhouse and Infirmary. Salary £120 per annum, with rations, furnished apartments, washing and attendance. Applications to Frank B. Coles, Clerk to the Guardians, Clerk's Office, Hackney Union, Homerton, N.E.

Kent County Ophthalmic Hospital, Maidstone.—House Surgeon Salary £100 per annum, with board. Applications to the Secretary.

Barra Parish Council.—Medical Officer. Salary £119 per annum. Applications to Thomas Wilson, Solicitor, Lochmaddy, Clerk.

Appointments.

Alford, E. Frank R., M.R.C.S.Eng., L.R.C.P.Lond., House Physician at the City of London Hospital for Diseases of the Chest, Victoria Park, London, E.

Ash, B. M., Assistant House Surgeon at the Salisbury Infirmary.

Bathurst Lacey, M.B., B.S., L.R.C.P.Lond., M.R.C.S., Senior House Surgeon to the Croydon General Hospital.

Davis Harry, L.R.C.P.Lond., M.R.C.S. D.P.H.Cantab., Medical Officer of Health for the Callington Urban District (Cornwall) for three years.

Births.

Sturges-Jones.—On Oct. 26th, at Deloraine, Half Moon Lane, Herne Hill the wife of W. E. Sturges-Jones, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

Naish—Willoughby.—On Oct. 12th, at St. John the Evangelist, Penge, William Vawdrey Naish, M.A., B.C., of Upton-on-Severn, son of the late William Naish, of Wilton, Wilts., to Madeleine Sophia Mason, youngest daughter of Joseph Willoughby, of Eastbourne, late of Plymouth.

Osborne—Watson.—On Oct. 26th at Childwall Parish Church, Liverpool, Albert Alfred Osborne, M.R.C.S., L.R.C.P.Lond., of Ilfracombe, youngest son of the late William Osborne and of Mrs. Osborne, of Bath, to Catherine Mary Metcalfe Watson, of Shrewsbury, elder daughter of the late Robinson Watson of Stockton-on-Tees.

Deaths.

Brookhouse.—On Oct. 27th, at 1, East Circus St., Nottingham, Joseph Orpe Brookhouse, M.D., F.R.C.S.Eng., Senior Physician of the General Hospital, aged 70.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, NOVEMBER 8, 1905. No. 19.

Original Communications.

COMMON DUCT CHOLELITHIASIS:

ITS SYMPTOMS, COMPLICATIONS, AND TREATMENT.

DELIVERED BEFORE THE NORTH-EAST LONDON CLINICAL SOCIETY, NOVEMBER 2ND, 1905.

By PROF. A. W. MAYO ROBSON, D.Sc., F.R.C.S.

MR. PRESIDENT,—Biliary concretions produce an entirely different set of symptoms, complications and dangers according to their position in the gall bladder, cystic, or common duct, for while gall stones in the gall bladder may produce little or no discomfort in the absence of infection, and may be present for years without being recognised until the onset of catarrh or some more acute infection, or possibly not until the advent of malignant disease, yet as soon as they leave the gall bladder and enter the cystic duct, the well-known seizures of biliary colic occur without jaundice, or with a very slight icteric tinge in the conjunctivæ due to extension of catarrh along the ducts.

According to the size of the stone in relation to the ducts and the intensity or otherwise of the associated catarrh, the symptoms may present every variety from mere evanescent spasms usually called indigestion, to violent colic, in which the pain may even lead to collapse and sudden death.

Obstruction of the cystic duct leads to another train of symptoms in the shape of retention of inflammatory products and the development of a tumour due to distension of the gall bladder, either mucus, or mucopus. Phlegmonous cholecystitis or even gangrene of the gall bladder may occur; and associated with it a local protective peritonitis nearly always develops and leads to great augmentation of the original tumour by visceral adhesions.

Perforation of the bile passages, general peritonitis, abscess, septicæmia, pyæmia, and other serious complications may follow. All these symptoms may occur without any evidence of jaundice, as they are compatible with a patent common bile duct.

In rare cases a large gall stone impacted in the cystic duct may by pressure on the common duct and on the portal vein cause both jaundice and ascites, and may thus lead to an error in diagnosis. If, in the more chronic cases, at the same time the gall bladder is distended, the combination of symptoms will give rise to a suspicion of malignant disease, or if the gall bladder cannot be felt and there are rigors and other signs of infective cholangitis, common duct cholelithiasis will be suspected.

As soon, however, as a gall stone enters the common bile duct an entirely different train of symptoms occurs, and a greatly enhanced series of dangers arises from an interference, not only with the excretory functions, of the pancreas but also with those of the liver.

SYMPTOMS.

Although Courvoisier estimated the presence of gall stones in the common duct to occur only in 4 per cent. of all cases of cholelithiasis, more recent observers agree that this is an underestimate, and I am confident from my own experience that in the early operations we frequently failed to discover concretions in the common duct; in fact, it is only since the adoption of the long upward incision, so as to enable the liver to be rotated or lifted up and the whole of the bile ducts thus to be completely under observation, has it been possible in every case to ascertain the true condition of the biliary passages. Thus I find that in 40 per cent. of my gall stone cases there have been concretions in the common duct.

It may be that this is a higher proportion than is usually found, for a surgeon who devotes special attention to some subject has a great many of the more difficult cases sent to him; but even arguing from my experience in hospital practice I find that my common duct cases bore the proportion of one-third to the whole.

Courvoisier said that in two-thirds of the cases only one gall stone was found. This again is contrary to my experience, for I find that a single gall stone is the exception, and that in quite 80 per cent. of cases the concretions are multiple.

The special combination of symptoms pointing to common duct cholelithiasis is a history of frequent attacks of pain, usually known as "spasms," which may have persisted off and on for years or for shorter periods, at first accompanied by jaundice, or at most by a mere icteric tinge in the conjunctivæ, then comes an attack in which well-marked jaundice follows within twenty-four hours of the pain. This as a rule heralds the passage of the stone from the cystic duct into the common duct. If the stone is small enough to pass, the jaundice may persist for a week or two with frequent recurrences of pain, and then the patient may obtain relief which may be lasting, or it may be that the gall stone becomes impacted in the common duct, when the jaundice persists and the liver soon becomes enlarged. In some of these cases the pain completely disappears after the first attack; though the jaundice continues; this is the class of case that so frequently gives rise to the suspicion of malignant disease, for the pain may have been comparatively slight, and the patient may give a history of the jaundice having come on without pain, which, when associated with rapid loss of flesh, deep jaundice, and enlargement of the liver, presents a picture that resembles one of cancer of the pancreas. It will, however, be noticed that the jaundice is usually less intense or lighter in colour in cholelithiasis than if the obstruction is dependent on cancer of the head of the pancreas, and the previous history of gall stone attacks as well as the history on close questioning, of pain preceding the present seizure, will usually afford some hope that the disease is simple.

Moreover, there is another sign that should always be noted. This I pointed out for the first time in 1887, before I knew that Courvoisier had described it a little time before. In cancer of the head of the pancreas there is usually distension of the gall bladder, whereas in common duct cholelithiasis the gall bladder can be seldom felt. The condition is probably due to the following combination of causes :—

(*a*) All cases of cholelithiasis producing symptoms are accompanied by inflammation of the walls of the biliary passages, as shewn by the almost universal presence of adhesions around the gall bladder.

(*b*) Gall stones in the common duct seldom cause complete obstruction, either because they are floating in the duct, or because they only partially fill it. There is therefore usually no sufficient backward pressure to cause dilatation of the gall bladder.

(*c*) The muscular coat of the gall bladder contracts in efforts of expulsion when there is any obstruction in the common duct.

(*d*) The contraction, from being at first intermittent, becomes in the long run, constant, and the accompanying inflammation fixing the contracted gall bladder, it atrophies.

Further help of an important character may be found by a careful examination of the urine, when, if the pancreas is involved, certain crystals can be found by an elaborate chemical process discovered by my friend Dr. Cammidge. If the crystals are acicular with sharp ends arranged in rosettes and dissolve in from 15 to 30 or 40 seconds in dilute sulphuric acid, the possibility is that the cause of the obstruction is either an interstitial pancreatitis alone or a pancreatitis secondary to an impacted gall stone ; whereas, if the crystals are thicker with more rounded ends and take a long time, from one to five minutes, to dissolve in dilute sulphuric acid, the probability is that the disease is cancer of the pancreas. I have found this test of great value in a considerable number of cases.

I would, however, point out that this test must not be taken alone ; though it will frequently assist one in a difficult diagnosis, which could only otherwise be settled by an exploratory operation.

If the gall stone is impacted in the pancreatic portion of the duct and thus obstructing the outflow of pancreatic fluid as well as the bile, we also expect certain changes in the fæces which are common to cancer of the head of the pancreas. These are characterised by the absence of bile and the presence of a large quantity of neutral fat in the motions, and if the patient has been taking meat, by the presence of muscular fibres. As an aid to diagnosis, an examination of the fæces has not received sufficient attention. It will usually be found that where the obstruction is due to gall stones not involving the pancreas, the neutral fat and the fatty acids are equal in amount, that the fæces are alkaline and contain some bile, but that where the pancreatic duct is obstructed either by a growth of the head of the pancreas or by a gall stone impacted in the pancreatic portion of the common duct, the neutral fat greatly predominates over the fatty acids and that the fæces are acid in reaction ; moreover, when the obstruction is due to cancer of the head of the pancreas the bile is entirely absent from the fæces.

If the gall stone or stones are not impacted, but are floating in a dilated common duct, a very characteristic train of symptoms will occur, pointing to infective cholangitis. In this case the gall stone acts as a ball valve, producing intermittent obstruction and with each attack the infected bile is forced back into the liver under pressure and becomes absorbed, giving rise to ague-like paroxysms, characterised by rigors, fever, and profuse sweating, each attack being followed by a deepening of the pre-existing jaundice and accompanied by pain, more or less intense. In nearly all these cases of floating gall stones in the common duct there is associated catarrh of the pancreas, which can be demonstrated by the metabolic and chemical tests in the urine and fæces that I have previously mentioned. Probably this helps to account for the rapid loss of flesh that frequently attends these cases.

I have had the bile examined in a large number of cases of infective cholangitis associated with gall stones and I find that the usual organism is the bacterium coli commune, and this in some instances where the condition has passed on to suppurative cholangitis, a very dangerous condition which leads to abscess of the liver and to other serious secondary complications. In two cases, however, where the symptoms were pyæmic in character, in one associated with suppurative parotitis at the time of operation, and in another with suppurative pancreatitis, streptococci were also found. Both these cases terminated fatally, and I suspect that wherever the bile and the pancreatic ducts are infected with streptococci, a fatal result must almost necessarily be the sequence.

I was interested, in reading Drs. Sargent and Dudgeon's lectures, to find that in suppurative appendicitis wherever streptococci existed in the peritoneum, a fatal termination generally if not always resulted.

In some cases the rigors are repeated with such regularity that a suspicion of ague will arise, and it has happened to me to have seen several cases where malarial fever had been diagnosed under circumstances which rendered it extremely probable. The greater number of these cases occurred in men who had lived in India or in other tropical countries, and in one patient who had been under observation in a nursing home in London, ague organisms were actually said to have been found in the blood ; and as the spleen and liver were enormously enlarged and there was very little pain, the conclusions arrived at could not be wondered at. His case, however, entirely failed to yield to quinine or other similar treatment, and I was then asked to see him and found and removed a floating gall stone from his common duct, with the result that he is now in excellent health. In this special case, as in all the cases of this class, the urinary test showing involvement of the pancreas proved of great utility.

In several cases I have removed gall stones from the common duct where the attacks were accompanied by rigors without any pain being complained of, and in others I have found common duct cholelithiasis without a history of jaundice.

A well-known surgeon recently said that in fully one-third of his cases of common duct stone there was no jaundice. This must, I think, have been an error of observation, for I have now operated on nearly 150 cases of common duct cholelithiasis, and although several have been said to be free from jaundice, in no single case have I failed to find an icteric tinge in the conjunctivæ after an ague-like seizure.

Those cases, occurring with very little pain and with very little jaundice, naturally come ticketed with various other diagnoses. Recently I saw a case of this kind, in a gentleman of 66, who was said to be suffering from chronic blood-poisoning due originally to an insanitary house ; the symptoms of blood-poisoning, however, completely disappeared after the removal of a number of gall stones from his common duct. Although I made my diagnosis on the physical signs and history alone, yet the diagnosis was strengthened by the discovery of the pancreatic reaction in the urine, and by the presence of 30 per cent. of fat in the dry fæces.

When gall stones are present in the gall bladder and cystic duct the pain commences under the costal margin and radiates to a point beneath the right shoulder blade, whereas when the stones are in the common duct the pain is more centrally situated, and usually passes to the mid-scapular region. It may, however, be epigastric throughout, and in several cases I have found patients to complain that the pain was chiefly situated on the left side of the upper abdomen. In these instances there have usually either been adhesions of the stomach to the gall bladder or well-marked interstitial pancreatitis. It should not be forgotten, therefore, that left-sided epigastric pain has in a number of cases been dependent on cholelithiasis.

Although Oberst and Beck have stated that they have obtained clear skiagrams of biliary calculi, I am bound to confess that in no single case have I received any help in diagnosis from the X-rays, and the only biliary stones that would be likely to prevent the passage of the Röntgen rays are those containing calcium.

The following complications may threaten life and require treatment, the original cause having perhaps disappeared or become masked :—

1. Ileus due to paresis of the bowel, leading to enormous distension of the abdomen, and to the symptoms and appearances of acute intestinal obstruction, apparently the consequence of violent pain.
2. Acute intestinal obstruction dependent on—
    (*a*) Paralysis of gut due to local peritonitis in the neighbourhood of the gall bladder.
    (*b*) Volvulus of small intestine.
    (*c*) Stricture of intestine by adventitious bands originally produced as a result of gall stones.
    (*d*) Impaction of a large gall stone in some part of the intestine after ulcerating its way from the bile channels into the bowel.
3. General hæmorrhages, the result of long-continued jaundice dependent either on gall stones alone or on cholelithiasis associated with malignant disease, or with interstitial pancreatitis.
4. Localised peritonitis, producing adhesions, which may then become a source of pain even after the gall stones have been got rid of. I believe that nearly every serious attack of biliary colic is accompanied by adhesive peritonitis, as experience shows that adhesions are found practically in all cases where there have been characteristic seizures.
5. Dilatation of the stomach dependent on adhesions around the pylorus.
6. Ulceration of the bile passages, establishing a fistula between them and the intestine.
7. Stricture of the cystic or common duct.
8. Abscess of the liver.
9. Localised peritoneal abscess.
10. Abscess in the abdominal wall.
11. Fistula at the umbilicus or elsewhere on the surface of the abdomen, discharging mucus, mucopus, or bile.
12. Empyema of the gall bladder.
13. Infective and suppurative cholangitis.
14. Septicæmia or pyæmia.
15. Phlegmonous cholecystitis.
16. Gangrene of the gall bladder.
17. Perforative peritonitis due to ulceration through or to rupture of the gall bladder or ducts, leading to extravasation of infected bile into the general peritoneal cavity.
18. Pyelitis on the right side due to a gall stone ulcerating or an abscess of the gall bladder bursting into the pelvis of the kidney.
19. Cancer of the gall bladder or ducts.
20. Subphrenic abscess.
21. Pleurisy or empyema of the gall bladder.
22. Pneumonia of the lower lobe of the right lung.
23. Chronic invalidism and inability to perform any of the ordinary business or social duties of life.
24. Gangrenous or suppurative pancreatitis.
25. Chronic interstitial pancreatitis.
26. Infective endocarditis.
27. Cirrhosis of liver.
28. Appendicitis due to the impaction of a gall stone in the appendix. I have seen this accident once.

Did time permit I could give examples from my own experience of each of these conditions. When once gall stones have reached the common duct, their attempted dislodgment by purely medical means is with few exceptions disappointing in the extreme, and the unfortunate patients are condemned to a lingering and painful illness, usually ending in death, unless the obstruction can be removed by surgical intervention. It is safe to affirm that there is no portion of the gall bladder, cystic, common or primary division of the hepatic ducts, which cannot under ordinary cicumstances be reached for the removal of concretions and that with great probability of success.

This ideal result, namely, a complete clearing of the bile ducts, can now be so effectually performed and with such exactness and certainty by the modified operation of choledochotomy which I had the honour of introducing, that it is unnecessary to describe any of the older procedures such as crushing calculi or short-circuiting the obstruction.

What was formerly a most difficult procedure, involving prolonged manipulation, special appliances, and at least two assistants, and only to be undertaken after all other means had failed, is now a comparatively simple operation in the greater number of cases, only requiring the help of one assistant and no special apparatus. By this method the time involved in the operation is reduced and where adhesions do not give unusual trouble it is easy to complete the work in from 30 to 40 minutes, which not only means a saving of time and fatigue to the operator, but a considerable saving of shock to the patient. I always employ a firm sandbag under the back opposite the liver, which not only pushes the spine and with it the common duct forward so that it is several inches nearer the surface, but acts like the Trendelenburg position in pelvic surgery by letting the viscera fall away from the field of operation. I then make a vertical incision over the middle of the right rectus, the fibres of which are separated by the finger, which I find to be the most expeditious and the most effective method of exposing the gall bladder and bile ducts ; but when it is necessary to open either the common duct or the deeper part of the cystic duct, instead of prolonging the incision downwards, as was formerly done, I now carry it upwards to the interval between the ensiform cartilage and the right costal margin as high as possible, thus exposing the upper surface of the liver very freely. It will now be found that by lifting or rotating the lower border of the liver (if needful first drawing the organ downwards from under cover of the ribs), the whole of the gall bladder and cystic and common ducts are brought quite close to the surface, and as the gall bladder is usually strong enough to bear traction, the assistant can take hold of it or of the free margin of the liver by his fingers covered with a dry sterile swab which prevents slipping, and by gentle traction can keep the parts well exposed, at the same time that, by means of his left hand with a flat swab or sponge under it, he retracts the ~~left~~ side of the wound and the viscera, which would otherwise fall over the common duct and impede the view. It will now be observed that instead of the gall bladder and cystic duct making a considerable angle with the common duct, an almost straight passage is found from the opening in the gall bladder to the entrance of the bile duct into the duodenum, and if adhesions have been thoroughly separated, as they should always be, the surgeon has immediately under his eye the whole length of the ducts with the head of the pancreas and the duodenum.

The surgeon, whose hands are both free, can now with his left finger and thumb so manipulate the common duct as to render prominent any concretions, which can be directly cut down on, the edges of the opening in the duct being caught by pressure forceps. When the duct is incised there is usually a free flow of bile, which it must be remembered is probably infective, but a sponge in the kidney pouch and rapidly mopping up the bile as it flows by means of sterilised gauze pads avoid any soiling of the surrounding parts, and if thought necessary, the bulk of the infected bile can be drawn off by the aspirator either from the gall bladder or from the common duct above the obstruction before the incision into the duct is made. After removing all obvious concretions, the fingers are passed behind the duodenum and along the course of the hepatic ducts to feel if other gall stones are hidden there, and a gall stone scoop, the only special instrument that I use, is passed into the primary division of the hepatic ducts in the liver and down to the duodenal orifice of the common bile duct. In order to insure the opening into the duodenum being patent, a long probe is passed into the bowel. The incision into the bile duct is now closed by an ordinary curved round needle held in the finger without any needle holder, a continuous catgut suture being used for the margins of the duct proper and a continuous fine green catgut or spun celluloid thread being employed to close the serous covering of the duct. In such cases, where the pancreas is indurated and swollen from chronic pancreatitis and is likely to exert pressure on the common duct for a time, insert a drainage tube directly into the duct and close the opening around it by a purse string suture, the tube being fixed into the opening by a catgut stitch which will hold for about a week. Where this is not done, I usually fix a drainage tube into the fundus of the gall bladder in the same way, as this drains away all infected bile and avoids pressure on the newly sutured opening in the duct.

Although there is seldom any fear of leakage or of infection, yet, owing to the separation of extensive adhesions, there is usually some tendency to pouring out of fluid in the first twenty-four hours. I therefore generally insert a gauze drain through a split drainage tube, bringing it out by the side of the gall bladder drain. The wound is closed in the usual way by continuous catgut sutures, first to the peritoneum and deep rectus sheath, next to the anterior rectus sheath, and lastly to the skin, the aponeurotic and muscular margins being further strengthened by from four to six sutures taking up all the layers; these sutures being of 20 to 30 day catgut.

Before I began to do this operation, the mortality of choledochotomy including every case, whether complicated or simple, was 16.2 per cent. (21.4 per cent., in the first series, and 9.3 per cent. in the second series, or together 16.2 per cent.) but since adopting the operation for complete exposure of the bile passages I have performed a continuous series of 76 choledochotomies for gall stones with only three deaths, a mortality of 3.9 per cent., thus amply verifying the forecast that I then made, when I stated that I expected the mortality would be reduced to 5 per cent. or less.

I have done my best to give a description of the symptoms, complications, diagnosis and treatment of common duct cholelithiasis, but what I want particularly to impress on my hearers is that as gall stones are well known to produce such serious complications and dangers as I have described, as they are usually diagnosed in their early stages before danger has arisen, and as their removal in this early stage can be effected with very little risk, at the outside 1 per cent., it seems to me that the wisest course is not to wait for complications to arise, but to advise the removal of the disease at an early period and so prevent the serious sequelæ.

THE INCREASE OF INSANITY IN IRELAND AND ITS CAUSES. (a)

By M. J. NOLAN,

Resident Medical Superintendent, Down District Asylum, Downpatrick.

II.—Statistical.

"Mathematics, with their severity and apparent precision, may teach the student to hide the weakness of reason under the force of ratiocination; they give simple formulas which are incapable of grasping reality and destroy 'that spirit of *finesse*' which is the common sense of life."—J. M. Guyan.

It is not proposed to labour with statistics. The figures relating to the increase of insanity in Ireland are indeed many and varied; but in the contention as to their real and apparent value in determining the point at issue they have been worn threadbare. The arguments they have furnished for and against have become so bald and hackneyed, that though the subject must be of necessity highly important to every thinking Irishman, yet it requires a special effort to approach it with enthusiasm. This is, perhaps, largely due to the fact that the figures are based on shifting sands of doubt, and tend to become blurred the closer they are investigated—every fresh wavelet of knowledge leaves them less defined and of shallower import.

In another sense they are or should be of the most valuable and interesting character, for the statistics of sanity and insanity are as it were the centre of a great circle which encloses the whole life of the people, a centre which has intimate touch with all the social conditions of the country, every point of contact forming other minor circles—those potent wheels within wheels which are the initial power in the revolution of the minds of men. But unfortunately such as they are they lack the fundamental quality which constitutes utility—they have no uniformity in the basis of comparative inquiry. Hence it were but waste of time to marshal the columns in detail, or boil them down in critical analysis; they best fulfil their function if we accept them as indicating the direction rather than as the result of investigation.

It may be said in extenuation that the investigation of any well-marked morbid bodily condition with a view to determine its relative frequency in different centuries would be extremely difficult, and would give, even with the greatest care, but doubtful results at best. Let us presume that a gynæcologist instituted an inquiry on such lines respecting, say, *placenta prævia*. On one hand he would have a complete lack of statistics, no institutional records, no local returns. On the other he would have his facts marshalled from great city maternities, from town and village hospitals, from professional knowledge of scattered medical practitioners and skilled nurses. And if such difficulty can be met in the case of an absolutely defined bodily pathological condition where there is no room for doubt, how impossible must it be to ascertain information of a scientific accuracy regarding mental disease, embracing every degree of psychical defect from congenital deficiency to the gradual devolution of senile decay. Added to which is the further difficulty that mental disease has been the subject of much legislation at the hands of parliamentary lawyers who framed definitions and limitations to meet the necessities of the adjustment of parochial rating and county cess, and with an entire disregard of medical considerations.

For all these reasons, though he is chiefly interested in it, that omniscient personage—"the man in the street"—who must, by the way, be the son of Macaulay's schoolboy—has no time or inclination to get to the bottom of any one aspect of the matter. He therefore contents himself with a general acquiescence in the catchwords of official statements, so that we hear on all sides expressions of irresponsible opinion that insanity is increasing by leaps and bounds, that the asylums are filling because the people drink too much tea and whiskey; that the life-blood of the nation is drained off by emigration; and that there is too much intermarriage; too much strain in towns; too much monotony in the country, etc., etc. No doubt mixed up with all this is that modicum of truth which gains currency for all such exaggeration, and secures it popular acceptance. Later we examine these and other causes; meanwhile, to obtain a grasp of the subject, we must endeavour to get hold of some of the more important leading data. Let us first briefly turn to the general question of population.

Fynes Morrison, in 1603, estimated the Irish subjects of Queen Elizabeth at 700,000, but the calculation is no doubt as erroneous as the picture he painted of the country is untrue, dipped as his pen was in gall and venom. The first serious effort to arrive at an accurate approximation was made in the "Political Anatomy of Ireland," by Sir Wm. Petty, in 1672, when he put it at 1,100,000. From that date there was a steady increase up to 1841, when the census returns showed a population of 8,747,588, and it is calculated there was even some further increase to 1845. Then came the turning point—Famine, Disease, and Emigration—a fateful trio devastated the country, sweeping away in less than five years the appalling number of 1,649,340.

(a) Being the second of a series of articles dealing with lunacy matters, specially contributed to the Medical Press and Circular.

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Ever since those dreadful days in the nation's history her population has been gradually tottering down, until to-day it numbers only 4,858,777—a drop of nearly four millions in a period of sixty years—a unique calamity in the history of modern nations.

Inseparably bound up with this unprecedented decline of the population is the emigration question, which in turn is so closely connected with the increase of registered lunatics. The enormous exodus which marked the disastrous decade 1841-51 got a continued impetus from the operation of the systematic emigration scheme devised by the Poor-law Commission of 1833, and the Devon Commission of 1840. The cure became speedily worse than the disease. Even as early as 1851 we find the laments of emigrants at leaving their country, and the laments of those left behind—mournful plaints in poetry and prose in the Press of that day. From that time, with some fluctuation, but without interruption, the march of emigration has gone on in such numbers that as shown by returns some five millions have left the country during the same sixty years within which the population decreased some four millions. But when we consider the potential increase of the population which would have inevitably resulted if these millions had lived and died at home, how inestimable is the loss to the country! To-day we are assured by the Bishop of Ross (*a*), who is in close touch with the agricultural necessities of the country, that "the population of Ireland has fallen below the numbers that are absolutely required to do efficiently the work of the country. Yet the flight of youth, strength, and enterprise continues from our shores."

From another standpoint His Grace the Protestant Archbishop of Dublin (*b*) sees the terrible evil. "It occurs to me," he says, "that one grave cause for anxiety in regard to the future not only of our Church but of the country through a large part of Ireland is the gradual but steady depletion of the population which is taking place; and the fact that for the most part it is the young and vigorous that are leaving our shores, presents the most serious aspect of the matter as bearing on the future!"

Here we have two terrible facts clearly established—a population reduced by nearly four millions and an exodus by emigration of nearly five millions all within sixty years.

We have now to turn to the figures more directly bearing on registered lunacy, and here it is, unfortunately, that reliable figures utterly fail us, and we must be content with generalities.

Just ten years ago an investigation as to the alleged increase of insanity was made by the Inspectors of Lunatics, who wrote:—

"The facts and statistics we have yet obtained and the reports of the different Resident Medical Superintendents throughout Ireland do not justify us in stating with any pretence to scientific accuracy that conclusive proof exists that any general increase of insanity has taken place in the country. This arises chiefly from the insufficiency of lunacy statistics. The needed information does not exist, or, when it appears to exist, proves on examination to be imperfect.

"Nevertheless, the ever-increasing population of the insane, and steady yearly advance in the numbers of first admissions point to the conclusion that some absolute increase of insanity is taking place in certain districts of the country." It would, indeed, seem impossible for those who had recourse to every available channel of information to come to any other verdict. At the present time they have at the end of another decade gathered up all further knowledge derived in the interval. Their matured opinion must be awaited with anxiety, as there can be little hope that it does not agree with, if it does not strengthen, that already formulated. It could scarcely be otherwise in the view of the following tables taken from the General Report of the Commissioners for the Census of 1901, which shows the number of lunatics and idiots in Ireland in 1851, 1861, 1871, 1881, 1891, and 1901, at large, in asylums, in prisons, and in workhouses, as returned in the Census Forms:—

	Lunatics.					Idiots.					Total
Years.	At large	In asylums	In prisons	In work-houses	Total	At large	In asylums	In prisons	In work-houses	Total	Total Lunatics and Idiots
1851	1,073	3,234	273	494	5,074	3,562	202	13	1,129	4,906	9,980
1861	1,602	4,613	273	577	7,065	5,675	403	21	934	7,033	14,098
1871	1,343	7,141	5	1,274	9,763	5,147	410	2	1,183	6,742	16,505
1881	943	7,547	—	1,284	9,774	4,548	1,896	—	2,195	8,639	18,413
1891	893	11,265	—	2,787	14,945	4,077	996	—	1,170	6,243	21,188
1901	596	16,587	—	2,651	19,834	3,272	763	—	1,181	5,216	25,050

The point of immediate interest in these figures is that Ireland in 1851, with a population of 6,515,588, had but 5,074 lunatics, or 1 in 1,291; and that in 1905, with a population of 4,588,776, the number of lunatics under official cognisance had risen to 19,834, or 1 in 225.

To discuss the actual value of this latter figure in estimating the mental condition of the present population, it is necessary to refer more particularly to the "first admissions" referred to in the last paragraph of the extract quoted above.

Now "first admissions" may be taken generally as the equivalents of "first attacks," on the frequency of which the increase or decrease of occurring insanity can alone be accurately determined, ***provided that the admissions result from a uniform procedure, and that the circumstances are identical in every respect.*** If such were the case in Ireland we would have unquestionably a steady yearly advance in the number of "first admissions," and consequently as a necessary result a steady annual increase in the occurring insanity. True it is that returns show the annual increase of "first admissions," but how many and varying have been the circumstances affecting the admissions of patients to District Asylums between 1851 and 1905.

Imperial Legislation, the action of the local administrative bodies, popular sentiment, social environment, the changes in the aspects of family life, the facility of movement, and countless other minor circumstances have all contributed to send those mentally affected to lunatic asylums in recent years, who, if they lived in more remote times, would never have helped to swell the lists. Who would venture to assert with confidence that there is a great increase in the numbers of persons suffering from myopia or presbyopia because so many more people are wearing glasses? Is not the solution to be found in the "sight testing" machine so easily available on the counter of every village chemist, jeweller, and ironmonger? This digression is necessary to bring to mind the uselessness of making an absolute comparison between those striking figures—

	1851	1901
Lunatics	5,074=1 in 1,291	19,834=1 in 225
Population	6,515,794	4,458,775

In this same connection we must again refer back to one special aspect of emigration which still tends to reduce the apparent importance of this one in 225. To do so we cannot do better than quote from the report made by the Mitchell Commission on Irish Lunacy matters:—

"The persons who have emigrated from Ireland consist almost entirely of those who are sound in mind and body. Emigrants have always been of this class,

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(*a*) Proceedings Catholic Truth Conference, October 11th, 1905.
(*b*) Proceedings Dublin Diocesan Synod, October 16th, 1905.

but it is more true of them now than formerly, because in so many of the countries to which they go the emigration of weakly persons is prohibited. There is an exodus of the strong and the sound, but the infirm, the insane, the imbecile, the idiotic, the deaf, mute, and the blind are left behind. Emigration thus leads to an undue proportion of defective persons of all sorts to the population in the districts or countries from which it is taking place, and those persons cannot properly be said to belong to the population among whom they are found. *They properly belong to a larger population.*"

Yes, they belong not only to the actual residual population in Ireland, but to that "greater Ireland" beyond the seas—to those millions in America, Canada, and in Australia and New Zealand. The latter countries, it is claimed, have been built up by Irishmen, and "are as much Irish—and, indeed, they are far more Irish than they are British." (*a*)

Those who have gone are not all successes. They, too, have had their failures, but they are on the whole the material for empire building, and their loss to the home country is grave beyond measure. It is but a matter of calculation to give a numerical estimate of the potential value they would have been in the "Old Country" (*b*), but what benefit would accrue from vain speculation? The people are gone, and we can only wish they could return us even in part their brains and energy. How much more valued it would be than the doles of gold which come from them as magnets to attract others away!

What conclusions, then, are we to draw from this increase of insanity in our country? They are in truth sad. It is not alone the alarming fact that one in every 225 of the entire population is mentally deficient—and this in itself is a lamentable record—but we have also to bear in mind that owing to the operation of emigration largely, but also to other causes which shall be noted, the potential sane influences in each year become more and more restricted. For this decrease of the mentally sound is coincident with the normal increment of the population so far as its intrinsic growth is concerned (the latter is evidenced by the excess of the birth over the death rate). It is, then, not difficult to see the trend of our mental stability—an undeviating march into the "sunless land"—Cimmerian, shut out from the light of reason. Is this increasing mental decrepitude to drag downwards the people to their final and utter destruction—"Quos Deus vult perdere, prius dementat." Such cannot surely be the fate in store for posterity. Apart from all sentiment, there is still remaining in the country a nucleus which, under proper conditions may put a limit to the production of the "unfit" and create a larger sound stock.

The mental constitution of a nation cannot be gauged by the extent of its organisation to deal with those mentally deficient. From this point of view it matters little whether they are wandering at large and uncared for, or confined to asylums or colonies. Lunatics they still are under each and every condition, and the mere transference of them from one column to another of our statistical returns does not touch the root of the evil. Such a "cause" as the accumulation of the insane in the asylums might be immediately removed by the dispersal of some thousands therein to "family care." Would such a step tend to any elevation of the mental power of the population, even if it were followed by a brisker mortality?

There are other methods also by which national lunacy may be "scotched" but not killed. At the present moment this is being done in Glasgow, where, by means of what has justly been described as a "very clever dialectical trick," many persons whose mental condition necessitates custody are allowed by the winking of the central authority to be treated elsewhere than in asylums, and consequently they do not swell the number of the registered insane. They may be "nervous" or "incipiently insane," or anything, in fact, which is not applied to a recognised form of certifiable insanity. By such a shallow subterfuge (however justifiable the results may be to parochial economics) the appearance of the statistics are no doubt improved, but is there any corresponding and resulting improvement in the national mental state? The individuals suffering from "uncertifiable insanity" are lunatics in the pathological degenerative sense, whether they are treated in a police cell, a "mental hospital," or a district asylum. Certification merely brings them within the ken of official cognisance, and thereby accentuates the fact of a distressing condition in social life, which unfortunately seems to be widespread. In their forty-seventh (1905) Annual Report the Commissioners in Lunacy for Scotland state in comment on their table showing increase of registered lunacy:—

"But while this table affords a trustworthy view of the progress of certified insanity among the pauper insane in counties and in all Scotland from year to year, it must be carefully noted that it does not settle the question of whether mental unsoundness is increasing in the community, nor does it enable a correct judgment to be formed of the comparative prevalence of insanity as between one county and another, both of which questions rest, as we have already indicated, upon a special series of considerations."

In their summary of final conclusions they go on to say:—

"The proportion to population of admissions to establishments of pauper patients shows in the course of thirty years a considerable and almost constantly progressive increase, common to all parts of the country."

Then in England, the Commissioners in their fifty-ninth Report (1905) state:—

"*Ratio of the Insane to the Population.*—On January 1st, 1905, the total number of notified insane in England and Wales stood to the estimated population in the proportion of 1 to 285, or in other words the ratio of the insane for 10,000 of the population was 35.09, showing an increase of 1.09 per cent. on the ratio for the same day last year—namely, 34.71. The actual numerical increase of the insane was from 117,199 to 119,829, or 2.2 per cent. In 1896 this ratio was 31.31, so that it has in the nine years increased by 12.07 per cent., the proportion of the insane persons in the community having risen from 1 in 319 to 1 in 285 in the same period. The increase of population in the nine years has been 10.8 per cent., whilst that of the number of insane has been 24.2 per cent."

With such statements before us, not for comparison, since inverse conditions exist, there cannot be any reasonable doubt that in the face of a falling population in Ireland and an increase in the number of registered insane, the dreaded increment of freshly occurring insanity must be in active operation. The causes of this increase must be our next consideration.

PUERPERAL SEPTICÆMIA, WITH SPECIAL REFERENCE TO THE VALUE OF ANTISTREPTOCOCCIC SERUM.

BASED ON AN OBSERVATION OF SIXTY-ONE CASES. (*a*)

By NATHAN RAW, M.D., M.R.C.P.Lond.,

Physician, Mill Road Infirmary, Liverpool.

I know of no disease affecting the human body which is more distressing to observe, or more relentless in its attack, than a virulent infection of puerperal septicæmia. In a civilised country labour ought to be a comparatively safe and certain process, but it is at once transformed into a dire calamity by the invasion of pathogenic organisms from without, an invasion which, in the great majority of cases, is preventable, and therefore ought to be prevented. What we owe to Lister and the adoption of antiseptic and aseptic surgery no living man can tell; suffice it

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(*a*) Mr. Wm. Redmond, "The Irish Abroad."

(*b*) It has been estimated that between 1831 and 1841 the population increased by 893,271.

(*a*) Read before the Liverpool Medical Institution.

to say that in no domain of medicine or surgery has the benefit been more observed than in the conduct of obstetric cases, and thousands of women have been spared who otherwise would have succumbed to this dread disease.

To use the term puerperal fever in the same way as scarlet fever or typhus is, in my opinion, erroneous, and it would be well to discard the word fever and to name it puerperal septicæmia. Many are the theories which have been advanced to account for the disease, but the only one which will bear the test of discussion is that which regards it as in no way differing from what we ordinarily call pyæmia or septicæmia.

For convenience it is desirable to divide the subject into two sections:—

1. Puerperal sapræmia.
2. Puerperal septicæmia.

In the first group of cases—the sapræmic—the symptoms are not, as a rule, serious, and local treatment, such as washing out the uterus and removing decomposing pieces of retained placenta, will generally suffice, if practised early. It is rather to the second group—the true septicæmic—that I wish to direct attention.

"It is probable that any decomposing matter may infect, but that some forms operate with more certainty and greater virulence than others" (Playfair). It has been affirmed that sewer gas or badly-ventilated houses will produce it, but I very much doubt it, as when one considers the conditions of the houses of the very poor, it is surprising how comparatively few cases arise in them.

Fortunately for us all the most potent organisms—viz., the streptococci—are not conveyed in the atmosphere, otherwise few women would escape infection.

One of the most extraordinary things in connection with this disease is the tenacity of the poison and the length of time that it will linger in the person of the nurse or physician. I have myself had three women under my care, all of whom were infected by one nurse in the course of a week, and there are numerous examples of localised epidemics all traceable to the practice of one obstetric nurse.

There are many extraordinary instances in which the unhappy property of conveying contagion has clung to individuals in a most mysterious way, and I have known several cases in which both nurses and doctors have had to abstain from attending labours on this account. Some have thought the individual saturated with some special poison which he could not get rid of, but I venture to think that a thorough scrubbing with antiseptics and the wearing of sterilised rubber gloves would soon remedy this supposed defect.

There are also some of the infectious diseases which are highly dangerous to the lying-in woman, chief of these being erysipelas, scarlet fever and diphtheria. In my opinion by far the most dangerous is erysipelas, however mild the attack. It is for this reason that it is not judicious to attend obstetric cases in general hospitals, where it is so easy for the septic process to be started. There is, however, little danger in a medical man or nurse attending such cases concurrently with the labour, provided that ordinary antiseptic precautions be taken in examination and delivery. There is, however, no doubt that scarlet fever arising in the house, or in the woman, will produce puerperal septicæmia, and Braxton Hicks has quoted 68 cases seen by him in consultation in which the poison was traced in no less than 37 to scarlet fever.

Diphtheria is capable of producing a most malignant form of endometritis and septicæmia, characterised by the formation of a dense diphtheritic membrane over the whole of the endometrium and cervix, and all the toxic symptoms of the disease. A most interesting example of this came under my notice last year, for the details of which I am indebted to Dr. Llewellyn Morgan, who was attending some members of the family, but not the confinement. A midwife, while suffering from diphtheria, attended three women in confinement, two of them coming under my care at the hospital, whilst the third died at home. Almost every member of the family was attacked by diphtheria, and one of my patients died. I operated on both, scraping away enormous masses of thick greyish diphtheritic membrane, which, on examination bacteriologically, was a pure culture of diphtheria bacillus. One woman recovered, the other died.

Bacteriology.—The pyogenic organisms which have been described as causing puerperal septicæmia are numerous, the chief being:—

1. Streptococcus pyogenes or Streptococcus erysipelatis.
2. Other forms of streptococci not yet accurately classified.
3. Bacillus colicommunis.
4. Staphylococcus pyogenes aureus.
5. Staphylococcus pyogenes albus and other staphylococci.
6. Micrococcus tetragenus.
7. Pneumococcus.
8. Gonococcus.
9. Diphtheria bacillus (Klebs-Löffler).
10. Coccus of scarlet fever.

By far the most constant organisms found in an acute case are, of course, the streptococci, especially the pyogenes, with occasionally other varieties. This is the coccus which multiplies at an extraordinary rate, spreads rapidly by the lymphatics and blood stream and kills the patient quickly, unless some counter-measures can be rapidly adopted. Then next in frequency are the staphylococci, more especially the S. aureus, but often there are mixed varieties. These organisms are not so virulent, spread more slowly, and can often be combated by the patient herself. In some cases, however, I have met the most malignant forms of puerperal septicæmia terminating fatally in which I have only been able to discover bacteriologically and microscopically Staphylococcus aureus and albus.

We come now to a most dangerous infection, viz., that from the Bacillus coli-communis, and I think it is only in recent years that we have learnt how very virulent this bacillus may be. It seems certain that the infection is always conveyed from some fæcal matter around the genitalia to the vagina or cervix, or even into the uterus itself by hands or instruments. I have found this organism alone in a great many of my fatal cases, and no treatment seems to have much effect.

With regard to the other organisms described I have never been able to isolate pneumococci or gonococci, and I doubt if either will produce septicæmia, although we know that virulent pneumococci will produce peritonitis. Certainly if gonococci could produce the disease *per se*, a great many women would be affected, but this is not my experience, as I have seen scores of women with gonorrhœa delivered without infection. I am certain that scarlet fever and diphtheria will both produce true septicæmia, and it is well known that the streptococcus of erysipelas is most virulent to parturient women.

The following table will show exactly the nature of the organisms found in my 61 cases of puerperal septicæmia. It is my practice at the hospital to have specimens of discharge and blood if necessary examined at once in the hospital laboratory, so that we can be informed at once of the nature of the infection. This is readily done, and is of the greatest value in directing our treatment.

MICRO-ORGANISMS FOUND IN SIXTY-ONE CASES.

Cases.	
27	Streptococcus pyogenes
6	Staphylococcus aureus; staphylococcus mixed infection
13	Mixed infections
11	Bacillus colicommunis
1	Diphtheria.
3	No growth of organisms.
—	
61	

Symptoms.—In a great many cases the disease commences insidiously generally within two or three days after delivery. If the symptoms develop after a week, the cause is usually some decomposition of retained membrane or placenta in the uterus. The patient complains of chilliness and occasionally there is a rigor; on examination the temperature may be found to be 101 degrees or anything up to 104 degrees or 106 degrees, according to the severity of the infection. It must, however, be borne in mind that it is not uncommon for parturient women to develop a temperature of 102 degrees or 103 degrees without any apparent cause and otherwise feeling well, and, therefore, a rise of temperature by itself would not necessarily indicate infection. It may be caused by auto-infection from overloaded bowels, and a good saline purge will soon reduce it. The pulse is increased —always a danger-signal—to 120 or 140. The patient is sleepless, with an anxious expression and sallow countenance. Pain as a symptom is very variable: some patients complain of intense pain at the lower part of the abdomen and the uterus is tender on pressure; in other cases no pain is ever complained of. Intelligence is unimpaired, and unfortunately this is often the case even to the time of death. The lochia are generally suppressed or altered in character, and usually slightly offensive in odour; in the sapræmic cases it is very offensive. Diarrhœa, vomiting, abdominal distension and delirium may ensue in the worst cases, and generally point to a fatal issue.

The method of spread of the infection, then, determines the local symptoms. In a great many cases peritonitis follows early in the attack, and extension to the pleura and pericardium is common in severe cases. I have had three cases under treatment in which the joints were affected with acute suppurative arthritis requiring operation and drainage. In two death ensued; the other recovered with a stiff knee-joint. Abscesses may form in the connective tissue in all parts of the body and in no way differ from ordinary metastatic abscesses met with in other septic diseases.

We should bear in mind that acute malarial attacks may supervene on delivery in women who have lived in tropical climates and who have suffered from malaria. It is characterised by severe rigors and high temperature, but rarely commencing before the fifth or sixth day after delivery. Leucocytosis is again an important indication of the onset of an acute septic process, but in puerperal septicæmia cannot always be relied on.

Treatment.—My chief object in bringing this subject before you is to give you my experience of the value of antistreptococcic serum, as I have an excellent opportunity of testing it. Before referring to it in detail, perhaps it would be desirable to discuss other methods of treatment. There is no disease in my experience in which it is so important to commence treatment early. The first thing to do, when sepsis is suspected, is to remove the cause and prevent its spread. For this reason a careful and minute inspection of the genitalia is necessary to discover any tear or laceration which is absorbing septic matter. The vagina and cervix should be examined with the same object. By far the most important treatment is to give an intra-uterine douche of some powerful germicide, and if possible to explore the uterus with the finger in search of retained membranes, placenta or blood débris. I have found the best antiseptic lotion to be chinosol. It is necessary to bear in mind that occasionally fluid will pass along the Fallopian tubes into the peritoneum, as happened once in my experience, hence there should be a deep groove in the intra-uterine tube, and little pressure should be employed.

The question of curettage of the uterus is debatable. In some cases a large blunt curette may be employed, but great caution should be used, as in some cases sinuses have been opened and new channels for infection provided, or it is easy to push it through the soft uterus, and then the result is disastrous. I pin my faith to large doses of quinine and stimulants, 10 grains of quinine as the first dose and 5 grains every four hours afterwards, until cinchonism is produced. Brandy, or whiskey, or port wine is useful, and supports the patient's strength, enabling her to battle against the attack. Tincture of perchloride of iron often does good, and many people have a great belief in veratrum viride, but I have never seen it do good. Many other drugs have been useful, especially sedatives and hypnotics at night, as well as a good nourishing fluid diet. The uterus and vagina should be repeatedly washed out and lightly packed with iodoform gauze, or what I always employ—branalcane gauze.

In spite of all such treatment a great number of cases require something more to counteract the deadly effects of the toxin. We have had, in my opinion, a most valuable remedy to our hand for some years, viz., antistreptococcic serum, but owing to the fact that it has often been used in other than streptococcal infections, it has fallen into disrepute in the profession. From the very nature of things it can only be of service in cases where the infection has been proved to be due to streptococci, and if used in cases of bacillus coli and other infections, we must not be surprised at failure. This serum, quite unlike diphtheria serum, is not antitoxic, but rather anti-microbic in its action, as streptococci produce little or no toxin.

Marmorek was the first to produce a serum for streptococcic infection, and as the serum is manufactured from living cultures of streptococci, it is not free from risk. In the first place the virulence of the cultures must be greatly enhanced by the passage through a susceptible animal such as the rabbit. The number of passages required varies from 20 to 30, at the end of which time the virulence does not become exalted by further passages; the culture may therefore be termed a fixed virus. (Hewett) Animals have now to be immunised to streptococci, and the horse, ass, or mule may be employed. The animal is first injected with a small dose, which is gradually raised until it is completely immunised, this being shown by the injection of 100-200 c.c of culture without harmful effect. The period of bleeding the horse for the purpose of obtaining the serum is highly important, as Marmorek found its blood to be toxic for 15 days after the last injection of culture. Marmorek thinks that all streptococci are identical, but others are of a different opinion, and recommend immunising against all varieties of streptococci. The serum is then standardised and ready for use.

The therapeutic effect in a typical case of streptococcic serum is marvellous. The dose I always employ is 20 c.c. injected with antiseptic precautions under the skin of the abdomen, and repeated twice daily. The temperature falls and the patient perspires and often falls asleep, whilst the pulse-rate is markedly decreased. I show here several typical charts illustrating the value of serum. If the temperature is not affected after six doses of 20 c.c., then I think it will be useless. It is highly important that the serum should be fresh and obtained from a good firm, as the greatest care is necessary in its manufacture.

Six years ago I had a patient who was nearly killed by antistreptococcic serum, as after every injection she developed rigors and high temperature. I suspected the serum, which was dry, and to my horror found it contained numerous living streptococci which grew readily on agar. I notified the firm, who after examination confirmed my diagnosis, and it was all withdrawn from the market, and a fresh start made in its manufacture. The cause was easily discovered: the porcelain filter which was used allowed living organisms to pass into the filtrate through a crack. Since publishing that case, in February, 1898, I have repeatedly tested the various antistreptococcic sera on the market, and I have invariably found them free. I use that supplied by Parke, Davis and Co., or the Pasteur Institute, and have been much pleased with both. I have never seen harm result from its use; on the other hand numerous cases of erysipelas, septicæmia, and other pathogenic infections have been saved by it. I never employ it unless streptococci have been found in the discharge from the uterus, as it is otherwise useless; but I think my tables will show that it is a valuable addition to our present means of attacking what is, in my opinion, one of the most virulent and distressing diseases which we are called upon to treat.

Table I.

Total number of cases under observation in Mill Road Infirmary, Liverpool.

No.	Recovered.	Died.	Death-rate.
61	32	29	48 p.c.

Table II.

Number treated with Antistreptococcic Serum.

No.	Recovered.	Died.	Death-rate.
37	24	13	36 p.c.

Note.—Serum was only used in those cases where streptococci were found.

Table III.

Number treated without Serum.

No.	Recovered.	Died.	Death-rate.
24	8	16	60 p.c.

Several patients in Table III. were admitted in an advanced stage of the disease, when obviously no treatment would be of avail.

In conclusion, I would like to summarise as follows, as the result of seven years' observation of its effects on numerous and varied pathogenic infections:—

1. Streptococci must be demonstrated by the microscope, and confirmed, if possible, by cultures, before the serum is used.
2. The serum must be used in an early stage of the disease if its full benefit is to be attained.
3. The doses should be large and repeated often.

I would like to express my high appreciation of the work and kindness of my junior colleagues, past and present, at the hospital, and of their kind co-operation and assistance in this research.

Out-Patient Departments.

WEST LONDON HOSPITAL.

CASE OF
INFECTIVE CYCLITIS
FOLLOWING AN INJURY TO THE RIGHT EYE, RECEIVED NINETEEN YEARS PREVIOUSLY.

By Percy Dunn, F.R.C.S.,

Ophthalmic Surgeon to the West London Hospital, Lecturer on Ophthalmology at the West London Post-Graduate College.

The following case is one of interest and, I think, worthy of being placed on record:—

N.S., a pale-faced married woman, giving her age as 32, came to my out-patient room on March 30th, 1905, complaining of loss of vision in the left eye. She gave the following history: When 13 years of age, nineteen years ago, she was knocked down in the roadway by a pair of horses, and sustained a severe wound over the right eye. The treatment which she received was that provided for her at home, that is to say, she was not taken to a hospital, and she made a good recovery. But for eighteen months subsequently she was troubled with diplopia. Then the double vision passed away, and about this time an attack of inflammation occurred in the left eye, for which she was advised to use a shade; as soon as the left eye had been covered she found that the fellow eye was blind. So far as the inflammatory attack in the left eye is concerned all that she remembers is that it quickly subsided under treatment, but she cannot remember whether or not she was taken to hospital, or of what the treatment consisted, nor can she remember receiving any treatment for the right eye at any time. The right eye has off and on always given her trouble, at times it was liable to be very painful, although she does not remember that it ever appeared to be inflamed. Three years ago it was first noticed to be wasted, and five weeks before she came to see me the eye had begun to become red, very tender to the touch, and persistently painful. About ten days subsequently to the onset of these symptoms she noticed that the vision began to fail in the fellow eye. In addition to the failure of vision the left eye became inflamed, and marked lachrymation and photophobia supervened. Two days before coming to the hospital she could not see across a room, or the time by a clock without going close up to it. Everything appeared as in a dense fog. She was just able to see to do her cooking, which was her occupation, but dared not trust herself in the streets without the assistance of a guide.

On examination the right eye was found to be atrophied, or in a condition, as test-books would so fancifully and absurdly describe it, of "phthisis bulbi"; it was deeply injected, very painful on palpation, and T.—3. The cornea was too opaque to render it possible to determine the condition of the iris or the intra-ocular structures.

The left globe, somewhat prominent, the result of myopia, showed slight injection; the pupil, regular though sluggish, reacted to light; there was no trace of plastic exudation either upon the iris or the anterior capsule of the lens; nor of punctate deposits upon Descemet's membrane, but an ophthalmoscopic examination was impossible owing to the photophobia. The patient was advised to come into the hospital at once for enucleation of the right eye. In three days' time she presented herself for admission, and the eye was removed on April 3, 1905. The recovery of vision in the left eye was rapid. Three days after the operation the sight began to improve, and on the seventh day she was able to read a newspaper, which had not been possible during the past five weeks owing to the failure of vision. She was discharged from the hospital on April 10, 1905. The vision in the left eye was retested on August 28, and the following result was obtained, viz.: $\frac{6}{\text{nil}}$—5 = $\frac{6}{18}$ nearly. J. 1 at 6", fluently, without a lens.

Remarks by Mr. Percy Dunn.—The term infective cyclitis made use of in the description of this case is one which I have for some time been advocating as being more in accord with modern pathology than that which is commonly known as "sympathetic ophthalmia." And in the discussion of this subject I must refer readers to my lecture which I delivered in the Post-Graduate College (published in the *Lancet*, August, 1904), in which the reasons for that innovation are explained at length. Moreover, in this lecture it is pointed out that the so-called "sympathetic irritation," which by so many observers is held to be a distinct disease from so-called "sympathetic ophthalmia," cannot be otherwise than merely a less virulent form of the infective malady. In the case above marrated the disease was of modified form, as proved by the fact that there was no plastic iritis, and yet, unless the source of infection had been removed, there is no reason for doubting that the patient would have become totally and permanently blind. But, apart from the precise pathology, this case presents several further points of interest. First, the patient is extremely indefinite as to any injury which the right eye received at the time of the accident. The only symptom of which she has recollection is the diplopia, which persisted for eighteen months, but her testimony in this regard cannot be deemed to be altogether trustworthy, inasmuch as had the eye not been severely injured, how otherwise could the leucomatous cornea be accounted for, and the atrophy of the globe which was present? Nevertheless, the right eye retained some vision after the accident, as is shown by the diplopia; on the other hand, as soon as the double vision ceased to be noticeable, the eye had undoubtedly become blind. Another point is the long period—nineteen years—which elapsed before the development of the infective symptoms. This goes to prove that the primary infection must have been of a mild, virulent type—an hypothesis which receives ample confirmation from the fact that the symptoms of infection produced in the fellow eye were only of a modified form. But within the limits of these remarks it is impossible to discuss with any fulness the subject of infective cyclitis. Nevertheless, the disease is one abounding in interest, replete with problems which have still to be determined, and environed with such difficulties of investigation that it is likely to afford for a long time to come ophthalmic surgeons a subject for interesting speculation.

Transactions of Societies.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held November 1st, 1905.
Professor Chiene, C.B., in the Chair.

Mr. Stiles showed the following patients:—(1) Case illustrating the treatment of General Peritonitis by Drainage. (2) Results of Operation for Aggravated Ununited Fracture of the Femur. (3) Patient after Operation for Strangulated intra-Abdominal Testicle. (4) A Case of Brancheal Fistula.

Dr. G. A. **Gilson** showed a case of symmetrical Enlargement of the Second and Third Digits of both Hands and Feet.

The following specimens were shown:—

The *Sp. pallida*, by Dr. **Sherman**. Sections and photographs of a localised duplication of the spinal cord, by Dr. Bruce. Prostate glands removed by supra pubic prostatectomy, stomach removed by gastrectomy for cancer, and ruptured extra-uterine gestation, by Mr. Miles. Tuberculous kidney, calculus pyonephrosis, hydronephrosis with hypertrophy of the opposite kidney, gangrenous and perforated gall bladder, strangulated intra-abdominal testicle, prostate, removed by Freyer's method, small intestine resected for fæcal fistula, malignant stricture of the œsophagus and various specimens of malignant disease of the bowel and rectum, by Mr. Stiles.

Professor **Chiene** then delivered his

VALEDICTORY ADDRESS,

in which he forsook the custom of reviewing the work of the two sessions during which he had held office, for a dive into the history of the Society. This, he said, was a year of centenary celebrations—John Knox, Sir Thomas Browne, Trafalgar, the Royal College of Surgeons of Edinburgh, and the Royal Medico-Chirurgical Society of London. He was specially tempted to linger over Sir Thomas Browne, of whom he always thought in association with his contemporaries, Isaac Walton and Wm. Harvey, that they taught us the value of tolerance and contemplation. After recalling the names of many Presidents of the Society who had shed lustre on its reputation, and on that of the Edinburgh school, he referred to some epoch-making papers read before the Society and remarked in conclusion that he knew nothing as a solace in the stress of work better than a little time given to the contemplation of the ancient worthies. There were three things a wise man ought to reverence—the Laws of Heaven, great men, and the words of good men. When Confucius penned these words he was thinking of his ancestors. As in the East we find that the worship of ancestors was a most important factor in bringing to a successful issue the recent great struggle, happily now ended, so possibly, in the battle of life, in which nowadays the struggle was severe, a little ancestor worship might be a helpful thing. Such a retrospect also taught us that our time here must come to an end, and for the relatives and friends of the members of the Society who had crossed the river, heartfelt sympathy would be freely given. Finally he handed over the pleasures and responsibilities of his office to his successor, Dr. Affleck, in the full assurance that the best interests of the Medico-Chirurgical Society would be safe in his keeping.

A very hearty vote of thanks was awarded to Professor Chiene for his valedictory address, and for his courtesy in the chair during his tenure of office.

Drs. **Lawson** and **Stewart** read some observations on the use of the

OPSONIC INDEX OF THE BLOOD IN THE DIAGNOSIS AND TREATMENT OF PULMONARY TUBERCULOSIS.

(Authors' Abstract.)

Starting with a description of the technique employed Dr. Lawson then went on to deal with the opsonic indices of the bloods of patients in health and those suffering from various forms of tuberculous disease. The observations of those submitted to investigation went to confirm the findings of Wright and Bullock that whereas opsonic indices within the limits of .9 and 1.2 were quite compatible with sound health, the indices of patients suffering from various forms of tuberculous disease were usually found to be outside these limits—for the most part below .9 in the more subacute and chronic forms, and above 1.2 in acuter conditions. One gland case showed an index as high as 2.4. This distinction was one which might be utilised for purposes of diagnosis in difficult cases. Under the action of tuberculin the behaviour of the opsonic indices of the bloods of healthy and of tuberculous patients also differed. Whilst in none of the few cases of healthy patients in whom tuberculin (T. R.) had been injected in small doses had the index failed to rise at once, in practically every case of tuberculosis it only eventually rose after an initial fall had taken place. This feature was of interest both in relation to diagnosis and treatment. The writers concluded by showing that so far as they had gone they had quite failed to establish any constant relation between the negative phase and temperature disturbance.

Dr. **Alexander Bruce** said that his experience of the value of the opsonic index as a guide to treatment had been favourable, and while he had not attained so marked a success as that claimed by Drs. Lawson and Stewart in lung cases, he was satisfied that in one case of myelitis, one of lupus, and one of glandular tubercle, he had observed most gratifying benefit.

Dr. **Gulland**, whilst appreciating the value of the work done was of opinion that the number of cells counted—30—was not sufficiently large to guard against error.

Mr. **Harold Stiles** hoped that in this method further observations would go to establish the claims which had been set up as to its value in diagnosis. Speaking as a surgeon he often had the greatest possible difficulty in determining whether a joint case was tubercular or not, and as the treatment to be adopted was active or passive, according as such proved non-tubercular or tubercular, any method which would enable him to decide definitely in such cases of doubt would be gladly welcomed.

Drs. Sherman, Beattie, and Caverhill having spoken, Dr. Lawson replied to some of the observations which had been made on his paper.

The following office bearers were appointed for the ensuing session:—President, Dr. James Ormiston Affleck, Vice-presidents—Professor Sir Halliday Croom, Professor Greenfield, Dr. Byron Bramwell. Councillors—Drs. John Macpherson, J. C. Dunlop, William Elder, R. A. Fleming, and F. D. Boyd; Professor Chiene, C.B., and Messrs. Alexander Miles and Alexis Thomson. Treasurer—Dr. Harvey Littlejohn. Secretaries—Dr. Lovell Gulland, and Mr. David Wallace, C.M.G. editor of Transactions—Dr. William Craig.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

Meeting held Friday, October 27th, 1905.
The President in the Chair.

THE RELATION BETWEEN CLINICAL MEDICINE AND PATHOLOGY.

The **President** delivered the opening Address on the above.

SPIROCHÆTE IN SYPHILIS.

Prof. **McWeeney** said since the discovery by Schaudinn last spring that a particular variety of spirochæte—the *Sp. pallida*—is of regular occurrence in syphilitic chancres, the observation has been confirmed by at least one hundred independent investigators working in all parts of the world; and the organism has now been found not merely in primary lesions but in the associated indolent buboes, mucous tubercles, unbroken cutaneous roseolæ, papules, and other forms of eruption, and also in the blood of cases in the secondary stage. Moreover, it has been found in the spleen, liver, and other internal organs of syphilitic fœtuses. In view of the probability that the organism may turn out to be the cause of syphilis, he thought it of interest to show some specimens which he had taken from chancres and condylomata at the Lock Hospital, from cases under the care of Drs. H. FitzGibbon and Pugin Meldon, to whom, as well as to Col. Baker, Major M'Leod, and Capt. Falkiner, R.A.M.C., the officers in charge of the Arbour Hill Military Hospital, he expressed his thanks for permission to use the material under their control. By way of contrast he showed *Spirochæte refringens*, a somewhat thicker and less closely coiled form from non-specific condylomata. Schaudinn has quite recently described locomotive organs in these parasites—terminal cilia in the case of *pallida*, and an undulating membrane in the case of *Sp. refringens*. Exhibitor showed by way of illustration, a specimen of a huge spirillum, 45μ. long, with cilia on each end, which he had cultivated from sewage.

BLOOD CONTAINING MAST-CELLS.

Prof. **McWeeney** showed specimens made from the blood of a man, æt. 34 (O'B.), a patient of Dr. Martin Dempsey, in the Mater Hospital, suffering from anæmia of obscure nature, attended with attacks of bleeding from the lower bowel, and slight albuminuria. The blood-count was very remarkable. Reds, 2,856,000; whites, 11.300; polynuclears, 46.5 per cent.; small lymphocytes, 15.3; large mono-nuclears, 27; eosinophils, 7.2; mast cells, 2.6—the coarsely granular cells being thus 9.8 per cent. of all leucocytes. There was marked mononucleosis, especially prominent being the large hyaline mononuclears. There was marked granular degeneration of the reds in many cases (punctate basophilia), but normoblasts were very scarce and megaloblasts were absent. Hg. 45 per cent. After a week under treatment with iron and arsenic the mast-cells had undergone marked diminution, specimens being hard to find, but the eosinophils were as numerous as before.

UNUSUAL FORM OF SENILE TUBERCULOSIS.

Prof. **McWeeney** also showed this specimen, which consisted of the lung of a woman, æt. 75, who in the street was suddenly seized with profuse hæmorrhage from the mouth and nose and died immediately after admission to hospital. At the autopsy a tuberculous condition of the lower part of the right lung was found, which had converted most of the middle lobe into a dense cicatricial tissue of greyish hue. The lower lobe was studded with very large slate-grey tubercles, and there was a single small cavity as big as a hazelnut which had ulcerated into a branch of the pulmonary artery and given rise to the fatal hæmorrhage. The cavity was lined with caseous matter, swarming with tubercle bacilli, many of which were peculiarly branched. The occurrence of fatal pulmonary hæmorrhage from tuberculosis in a patient æt. 75 seemed sufficiently unusual to justify its being brought forward.

HARVEIAN SOCIETY OF LONDON.

Meeting held October 26th, 1905.
The President, Mr. C. B. Lockwood, F.R.C.S., in the Chair.

Mr. **Herbert Tilley** read a paper on the

SYMPTOMS, DIAGNOSIS, AND TREATMENT OF SOME OF THE COMMONER FORMS OF NASAL OBSTRUCTION.

He pointed out the bearing of nasal obstruction on the physical degeneration of the youth of to-day. Unilateral obstruction in a child, with purulent discharge, was generally due to a foreign body. Recurrence of adenoid growths after operation is generally due to inefficient removal. The various forms of hypertrophic rhinitis were described, and the best methods of dealing with them. Deviations of and outgrowths from the nasal septum were a frequent cause of nasal obstruction in the adult and in a small proportion of cases induce reflex effects. In operating, care should be exercised in preserving as much of the normal mucous membrane as possible. Sub-mucous resection of the nasal septum was advocated—the operation was described. The necessity for intranasal splints was thus avoided, with their intolerable or objectionable accompaniments. Mr. H. Tilley emphatically condemned intranasal operation in cases of slow progressive deafness when the Eustachian tubes are patent and when inflation of the tympanum produces not even temporary improvement in the hearing. In cases where deafness was due to an association of catarrhal and sclerotic changes in the tympanic apparatus, some operation might produce benefit by removal of nasal obstruction if inflation of the tympanum improved the hearing; otherwise it is very doubtful..

Dr. **Scane Spicer** remarked on the difficulty of defining nasal obstruction, and the importance of collapse of the ala nasi during breathing as an indication thereof. In mixed cases of deafness with the presence of a definite catarrhal element, the latter might be removed by suitable nasal operation although the cure of the deafness could not be obtained.

Mr. **Pegler** referred to types of nostrils and to hypertrophy of the middle turbinate.

Mr. **Elmore Brewerton** read a paper on

EXTIRPATION OF THE LACHRYMAL SAC.

After giving a short history of the methods of destruction of the sacs, he described Kuhnt's operation and Cirincione and Axenfeldt's modifications, and mentioned the cases in which the operation was most urgently needed. He remarked on the frequency with which the extirpation was performed in Germany (Adolph has collected over 500 cases, nearly all giving excellent results), and urged that the operation was performed far too seldom in this country. At any of our ophthalmic hospitals patients could be found suffering from chronic dacryocystitis with all its dangers and discomforts, who had been attending for months, or even years. All of these patients could be permanently relieved of their trouble by extirpating the lachrymal sac.

THERAPEUTIC SOCIETY.

Meeting held October 24th, in Apothecaries' Hall, Sir Lauder Brunton, Bart., in the Chair.

The **Secretary** reported that Dr. Herbert French attended the London Health and Education Congress as a delegate. The most interesting therapeutical subject discussed on that occasion was the Physical Drill of Young Women, with elaborate movements, but many of the performers were not robust. The exhibits of trypanosomes in various stages of development under the microscope. The sterilisation of milk for the treatment of infants, accurately performed by the Aylesbury Dairy Company.

Mr. T. R. **Elliott**, of Trinity College, Cambridge, read a paper on Adrenalin, stating that it was derived from the cells of the medulla of the suprarenal capsules, the cells of which resemble those of the sympathetic ganglia. The sympathetic nerves form three divisions, cranial, thoracic lumbar, and sacral. The thoracic lumbar affect the same plain muscles as adrenalin locally applied does, and in the same way. Thus both constrict the blood vessels, except the coronary arteries and those to the lungs, both relax the muscles of the stomach and intestines, but neither acts on those of the bronchioles, and the action of both is in many cases opposed to that of the cranial or sacral visceral nerves, so that adrenalin gives a test for the connection of plain muscles with the different regions of sympathetic ganglia. To obtain the therapeutic effects of adrenalin it must be applied locally; if injected subcutaneously it only affects the area injected. If all the nerve cells which contain adrenalin are removed the animal dies from the circulation failing, but the sympathetic not containing adrenalin may be removed and the animal live. Adrenalin, therefore, might be used when the suprarenal glands are impaired, and perhaps in diphtheria and typhoid fevers, but its use must be empirical, as it is poisonous, causing, in large doses, inflammation of organs, nervous paralysis, and death.

Dr. **Steel** and Dr. **Plant** read a paper on the treatment of Serous Effusions by the Injection of Adrenalin Chloride. After tapping one drachm of adrenalin chloride with half-an-ounce to one ounce of sterilised water was injected through the cannula. In one case after one injection no return of fluid occurred for nine months. In two cases, though a little fluid returned after one injection, it was soon absorbed and did not again recur. A fourth case required three injections of adrenalin, when the fluid disappeared and did not recur. In another case, though the fluid did not entirely disappear, the time for tapping was extended to once in ninety-two days. The injection causes slight rise of temperature—2°F. for a few hours, and sometimes cutting pain in the liver, but no other ill-effects.

THE WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Clinical Meeting held on Friday, November 3rd, 1905.

The President, Mr. L. A. **Bidwell**, in the chair.

The following cases were shown :——By the **President**, a case of Congenital Syphilitic Disease of the Tongue. Mr. Bidwell pointed out that the patient, a woman, was not benefited by iodides, but improved rapidly under mercurial treatment. Her tongue was much worse when she was pregnant, but even when this was so she was delivered of a healthy child. Mr. Bidwell also showed for Dr. Beale a case of Congenital Papillomata of the Tongue, for comparison.

Dr. **Seymour Taylor** showed a case of Myoclonus, and pointed out that the causation of this condition was ill understood.

Two marked cases of adolescent Coxa vara, both males, were brought before the Society by Mr. **Macadam Eccles**, who demonstrated the marked elevation of the trochanter,and limitation of abduction, and also showed some beautiful skiagrams of the condition ; he also remarked that this condition was first drawn attention to in this country, though under another name, by a founder of the Society, Mr. Keetley.

Mr. **Laming Evans** then showed a case of Deformity of the Femur of uncertain nature, and also a femur obtained recently in the excavations at St. Bartholomew's Hospital, and which must be at least 200 years old ; but which showed marked signs of coxa vara.

Dr. A. E. **Saunders** brought to the Society three cases, one of Acromegaly, one of Osteitis Deformans, and a third of Myxoedema, and gave an instructive comparison and contrast of their similarities and differences.

A case of a new Growth of the Sublingual Gland was shown by Dr. **Leonard Dobson**, who said that it was most probably of similar nature to the mixed tumours more commonly seen in the parotid.

A case shown by Dr. **Hall Dally** was a very beautitiful example of enormous gouty deposits in both hands; the condition of the bones was demonstrated by skiagrams.

The meeting then adjourned.

France.

[from our own correspondent.]

Paris, November 4th, 1905.

Epistaxis and Liver Diseases.

The relation between epistaxis and affections of the liver has been known since the time of Hippocrates and Gallien, who drew attention to the fact that patients suffering from lesions of the liver bled frequently and almost always from the right nostril.

Monneret, some fifty years ago, attributed the majority of cases of epistaxis to liver disease of cardiac or tuberculous origin. More recently Verneuil, insisting on the relation of hæmorrhages and functional hepatic troubles, believed that hemophilia originated in a certain respect in the liver.

In all acute or chronic affections of the liver epistaxis is found. Temporary and benign in catarrhal jaundice, more frequent and more abundant, and consequently dangerous, in the grave forms of icterus and yellow fever. It often precedes an attack of hepatic colic, while it can be found in amyloid degeneration, in acute or chronic congestions of the hepatic organ resulting from cardiac disease. In hepatic syphilis in the adult epistaxis is rare, but in the child or infant it is very grave and constitutes an important symptom.

In cirrhosis, says Dr. Armand in a recent thesis, epistaxis is observed in every stage of the malady. It appears at the incipient stage of the disease, becomes less frequent during the development of the malady, but reappears with intensity at the terminal or chachetic stage.

When epistaxis occurs without any special reason in a patient suspected of alcoholism the condition of the liver should be carefully examined, as frequently latent cirrhosis will be discovered and arrested by appropriate treatment.

What is the reason, asks Dr. Armand, of this frequency of epistaxis in hepatic affections ? Of all the explanations given, the fact remains that the blood in persons suffering from hepatic affections coagulates with difficulty; and according to Hayem, it is analogous thus to the blood of persons suffering from toxic injections, whether from alcohol, saturnism, or simple digestive toxines, as in the cirrhosis of Boix.

It can be conceived, consequently, that these patients bleed the more easily that the blood is rendered more liquid and hence less coagulable.

Treatment of Epistaxis.

No matter what may be the cause, local or visceral epistaxis must be considered as hæmorrhage requiring local treatment.

In nine cases out of ten, the bleeding is due to local and varicose erosion of the septum. In examining the antero-inferior portion of the septum of an individual a vascular spot formed by the expansion of the terminal branches of the spheno-palatine artery can be seen. It is generally at this point that the hæmorrhage takes its origin.

The treatment of epistaxis is either simple or complicated according to the abundance of the hæmorrhage. For simple treatment the best is compression with the fingers, during ten minutes, of the cartilage against the septum. It rarely fails and should be always tried before anything else.

In case of failure, plugging with some styptic solution should be done after clearing out the clots. A large plug of absorbent wool steeped in one of the following three solutions—adrenaline, 1—1,000; antipyrine and water, equal parts ; and oxygen water, 12 vol. Perchloride of iron should never be used.

Certain precautions should be taken by the patient, such as rest, avoid blowing the nose, or sneezing, etc. If the hæmorrhage persists, more special treatment will be required and the choice is between anterior, and antero-posterior plugging. The former is comparatively easy and almost painless, but only practicable under the control of the rhinoscope. The instruments and material required are a nasal speculum, a pair of scissors, a forceps, and a narrow strip of antiseptic gauze, about a yard in length.

By the frontal mirror a strong light is thrown on the nasal fossa and the parts examined in detail, the nostril being kept dilated by the nasal speculum. Seizing with the forceps the extremity of the strip of gauze, the latter is carried to the posterior extremity of the fossa and by successive movements the gauze is packed in the cavity until it is completely obturated. Iodoform gauze should be avoided as it irritates the mucous membrane, nor should it be wetted, as it macerates the epithelium. In twelve hours the plug can be easily withdrawn by the forceps or the finger.

Posterior plugging should always be avoided unless rendered imperative. Such cases of obstinate epistaxis are generally observed in patients suffering from arterio-sclerosis, Brights' disease, or hemophilia.

The operation is effected with Belocq's sound or a common flexible catheter. The plugs will be left in situ forty-eight hours. A certain amount of danger from subsequent infection attends the operation, which is always very painful to the patient but nevertheless it has its utility. Should every case of epistaxis be promptly treated ? By no means. Where it occurs in aged persons it should be on the contrary respected or at the most moderated by the insertion of a simple plug. Many of this class have been known to succumb a few days after too effectual treatment to an attack of apoplexy. It must be remembered that in elderly people epistaxis is frequently nature's safety valve.

Prophylactic Treatment.

If the hæmorrhage is due to general causes, such as cardiac or hepatic cirrhosis, these affections must be treated. But when the cause is purely local, the erosion must be sought for at the point already named and cauterised. Before proceeding to do this, a plug of absorbent wool steeped in a five per cent, solution of cocaine should be applied for five minutes to the spot. Then the vessels are cauterised with either a solution of chromic acid (1—3), applied for half-a-minute, or a stick of nitrate of silver. During the following days the patient will be recommended to aspire ordinary vaseline morning and evening.

Austria.

[From our own correspondent.]

Vienna, November 4th, 1905.

Idiopathic Pericystitis.

At the Prague Verein, Walke showed the members three cases where no evident lesion could be traced that would give rise to acute pericystitis. The patients had always been in good health previous to the illness, which commenced without any apparent cause with acute fever, resulting in perityphilitis in the first case. The second case resulted in inflammation in the cavum retzii.

The pericystitis was accompanied with intestinal disturbance such as colic tenesmus, constipation, diarrhœa, and vomiting. Many of the idiopathic pericystitic inflammations are followed by perityphilitis. In the discussion Hilgenreiner said that most of these cases recorded in literature are associated with visicle fistula, alleged to be due to a morbid condition of the bowel as the primary cause.

Visceral Inversion.

Kitaj exhibited a case where complete inversion of the viscera existed as seen by the Rontgen Rays. The apex beat of the heart was present in the fifth right intercostal space, while the liver was in the left side and the spleen in the right.

He showed another case of paralysis from pressure on the ulnar nerve after a fracture of the olecranon and internal condyle which involved the nerve in the course of repair.

Thymus Extirpation.

Fischl gave a history of his experiments and results on the removal of the thymus gland, which had been prompted by reading Basch's results. His own experiments do not accord with that investigator. but on the contrary are negative. His researches were carried out on goats, guinea-pigs, and dogs and in every case no trophic disturbance or rachitis could be observed neither was there any inhibitory influence noticed in the healing process where artificial fracture was performed. His operations were carefully observed in six goats, eight dogs, and a large number of guinea pigs. In every case normal weight, development of bone, absence of rachitis were compared carefully with the control animal and no deviation from the normal condition could be observed. Around the fracture a large amount of callus was deposited, while cranial trepanation wounds and severe dislocations healed well.

In the discussion Basch said it was easy to perceive where Fischl had erred. His operations were carried out largely on animals with a vegetarian diet which would at once negative the rachitis. He had not operated on dogs in these experiments and would not discuss animals with Fischl.

Another important point in Fischl's experiments was the removal of the thymus. He seems to have drawn the thymus from below the sternum, whereas the sternum must be split and the gland totally removed to obtain the rachitic result.

Origin of Traumatic Cardiac Lesions.

Frank gave the history of a brakesman, æt. 39, who had suffered for fourteen years from articular rheumatism, for which he was treated in hospital. The last time he was received was for bronchitis after severe chill. The heart then was perfectly normal and healthy. A year ago he was thrown from a brake which injured his chest. He took little notice of it at the time, but shortly afterwards consulted Frank, who discovered nothing but the bronchitis. Six months later he was suddenly attacked with difficulty of breathing, fainting, verging on collapse. Frank then discovered that the heart area was increased in dulness towards the left with duller sounds, frequent pulse, which was arhythmic, the urine was normal. Under appropriate treatment he improved for a month and then again relapsed with cough and hæmorrhage. When exhibited at the meeting he had recovered strength, the heart area normal, but the pulse still 108.

Frank diagnosed this as myodegeneratio cordis with hypertrophy, as dilatation had been present. He still clung to the opinion that the accident had some share in the production of the lesion, although six months removed from it in time.

Operating Theatres.

GUY'S HOSPITAL.

Operation for Internal Injuries of the Abdomen received from Contusion without Open Wound.—Mr. Clement Lucas operated on a carman, æt. 26, who, in backing a pair of horses, had been pinned by the pole of the cart against a post, the pole striking him in the neighbourhood of the umbilicus. He had been admitted in a state of collapse suffering from intense pains in the upper part of the abdomen, the walls of which were rigid, whilst respiration was almost entirely costal. There was slight bruising of the skin just above the umbilicus. The patient's face was pale, pulse 90, respirations 20, temperature 96·5. He lay huddled up on his side, the legs being drawn up ; he vomited soon after admission ; the liver dulness was normal. Mr. Lucas saw him within two hours of the accident and considered the severity of the symptoms warranted an exploration of the abdomen. First chloroform and then ether was administered and an incision was made from the umbilicus downwards. A few ounces of blood were found in the peritoneal cavity ; the small intestine was for the most part contracted, and blue in colour. Feeling for the colon just above the umbilicus Mr. Lucas pulled down a badly damaged piece of transverse colon. In order to get a better view, it was necessary to extend the incision upwards, nearly to the ensiform cartilage. It was then found that between three or four inches of the transverse colon were entirely denuded of peritoneum and the muscular coat torn, but the mucous coat was not perforated The longitudinal muscular bands were torn across and projected outwards away from the surface of the intestine. Further examination showed a large blood clot below the hepatic flexure lying beneath the meso-colon. The peritoneum was here torn for about two inches. A jelly-like mass could be felt in this situation which proved to be the crushed pancreas. The slit in the peritoneum was at once sewn up with a fine continuous silk suture. A rent was next seen on the ascending colon just above the cæcum, dividing the peritoneum and muscular coat there ; it was two and a half inches in length and was sewn up with a fine continuous suture. The damaged transverse colon was now drawn out through the wound and packed round with sterilised gauze; it was clamped in two situations so as to include seven and a half inches of the gut; the corresponding omentum being then ligatured and cut away, and its meso-colon treated in the same way, four and a half inches of the crushed bowel were removed with scissors; Murphy's largest-sized button was used to unite the divided ends, and finally to make it more secure a continuous Lembert's suture was applied all round outside the button. Sutures were also used to bring together the divided meso-colon and mesentery. The intestine was washed with sterile saline fluid and the parietal peritoneum closed with a continuous fine silk stitch. It was now discovered that the left rectus muscle had been torn completely across just above the umbilicus; this rent and the sheath of the muscle were sewn together with interrupted chromic gut sutures. The muscles on the site of the incision were treated in the same way; a continuous horse-hair suture with some deep salmon gut retaining sutures was used for the skin.

Mr. Lucas drew attention to the case of a boy, æt. 15, who was run over by an omnibus on the previous day and whom he saw within an hour of the accident. The boy was quite conscious and his pulse, though feeble, had some volume; his lips, too, were pink and his pupils not dilated nor his skin sweating, as is commonly the case in acute hæmorrhage. He complained of intense pain over the region of the ensiform cartilage and lay with his knees drawn up. The history was that he had been knocked off a bicycle on his back and run over by two wheels of an omnibus containing fourteen people. Mr. Lucas said that on examination he found a graze opposite the left nipple and there was emphysema all over the left side of the chest as high as the clavicle. Mr. Lucas argued that the chance of doing good in this case did not justify an exploratory operation, as it was almost certain that with a wound of the lung as well as the severe abdominal injuries the patient would die under the anæsthetic. This opinion was well justified by the result, for the boy only lived twenty-four hours, and the *post-mortem* showed the following injuries: fractured ribs with a wound of the left lung and some hæmo-thorax, complete rupture of the left lobe of the liver (a piece lying loose in the abdomen), spleen torn in half and rupture of both kidneys. Mr. Lucas had argued that if chloroform were given the patient would die from the increased collapse, and if ether were administered the boy would die from lung trouble or from the hæmorrhage induced by the vascular tension caused by the ether. Mr. Lucas also said that an exactly similar accident to that in the case he had just operated upon came under his care a few years ago, in which a carman backing horses was pinned by the pole against a wall; this patient was also seen within two hours of the accident, and Mr. Lucas opened the abdomen to explore its contents. This man was rather taller than the present patient, and the bruise on the abdomen was rather below than above the umbilicus, and less severe damage was found to the transverse colon, whose peritoneal and muscular coats were stripped off the bowel for two and a half inches in a direction from left to right; this was sewn down with a continuous silk suture. A piece of small intestine completely cut across was next found and it was some time before its corresponding end could be discovered; by picking up the jejunum where the duodenum terminates and following it along, it was found that the distal end had first been picked up; these two ends were clamped for some distance from their extremities and packed round with sterile gauze. At this time the patient's condition became critical; his median basilic vein was therefore exposed and four pints six ounces of salt solution were introduced; this brought back the man's pulse. Some two inches of bruised bowel were cut away and the ends united by means of a Murphy's button. Two more rents were found in the mesentery, one of which was bleeding freely and these were sewn up. Another crack in the peritoneum was found over the cæcum, but as this looked recoverable, nothing was done to it. The abdomen was next thoroughly washed out with sterile saline fluid and then closed This patient recovered without a bad symptom; he passed his button on the twenty-first day. He was seen twelve months afterwards in perfect health, and said he had never suffered any inconvenience from the accident. The circumstance which brought him then to the hospital was of interest, Mr. Lucas thought, inasmuch as the man had to attend at a coroner's inquest for having run over and killed an old man in the street.

The case Mr. Lucas had just operated on lived six days. On the second day the patient developed a temperature of 102 and became very restless, complaining of extreme hunger and thirst. His abdomen remained supple and there was no evidence of peritonitis; during the next four days the temperature ranged from 99 to 101·8, and he gradually sank. A *post-mortem* showed that there was no peritonitis, that the button was perfectly secure and that the operation wounds were quiet. The pancreas both as regards its body and head was crushed into a pulp and there was post-peritoneal fat necrosis, apparently as the result of the action of the pancreatic juice. It had been noticed after the operation that his urine contained a considerable amount of sugar.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 8, 1905.

RELATION OF MEDICAL OFFICER OF HEALTH TO PRACTITIONERS.

A DEBATE of considerable significance took place at the October meeting of the Incorporated Society of Medical Officers of Health. The subject at issue was the relationship that should exist between the medical practitioner and the medical officer of health in respect to the administration of the Notification of Infectious Diseases Act and the isolation of suspected patients. The exciting cause of the debate was the publicity given to the facts that last year 10 per cent. of the patients admitted to the Metropolitan Asylums Board's hospitals were not found to be suffering from the infectious disease certified, and that these cases had cost the Board about £12,000. These matters had excited a good deal of comment in lay quarters and not a little adverse criticism on the sagacity of the certifying practitioners. Dr. Sanders, medical officer of health for West Ham, opened the discussion with a speech that contained many good points. He pointed out that it had been proposed that the medical officer of health, the superintendent of the fever hospital, and the general practitioner should be in closer touch with one another, and that the medical officer of health should be prepared to consult with the medical practitioner in doubtful cases of infectious disease, whilst if this duty put too great a strain on him he ought to be provided with extra assistants. Moreover, it had been said that if the isolation hospitals were to perform their full function, they should not only be prepared to receive the present percentage of doubtful cases, but that they should be furnished with still larger isolation accommodation, so that room might be found for all cases in which genuine doubt existed. Dr. Sanders then spoke decidedly on the question of errors in diagnosis. The public, he said, should not be led to believe that the profession was at fault, nor that it was as simple a matter to make a diagnosis during a short visit to a dirty cottage as to do so in a well-equipped modern hospital. Now this, it seems to us, is a point to which full weight should be given. The wonder is, not that 10 per cent. of errors are committed, but that only 10 per cent. were committed. Dr. Goodall, speaking from the point of view of a hospital superintendent, showed that the percentage of error hardly varied at all from year to year, and that in nearly all the wrongly-diagnosed cases the error was unavoidable. Thus, taking the mistakes with regard to diphtheria, he found that 86 per cent. of them were represented by tonsillitis, laryngitis, and similar acute affections of the throat in which it was of the highest importance that the patient should be properly watched and bacteriologically examined with a view to administering antitoxin early if a certain diagnosis of diphtheria were arrived at. Measles, too, was occasionally sent into hospital diagnosed as scarlet fever, but, said Dr. Goodall, the mistake was often pardonable, owing to the occurrence of a prodromal scarlatiniform rash, a condition which he confessed had deceived him, in spite of his long, special experience. Dr. Sykes, of St. Pancras, mentioned that in enteric fever the margin of error was as high as 25 per cent., but that considering the slow development of the symptoms of enteric fever and their oftentimes anomalous character, it was obvious that suspected cases ought to be watched in advantageous surroundings rather than detained at home for days and weeks till confirmatory signs were definitely forthcoming. In fact, it may be said that the opinion of the meeting was emphatically in favour of the high character of the discretion shown by practitioners in making diagnoses, and it seemed to be admitted that though occasionally mistakes were made that could have been avoided with greater knowledge or care, the great bulk of the errors were such as were unavoidable under present conditions. As to the reduction of these errors, two proposals, not in themselves mutually exclusive, were made: one that the medical officer of health, or an assistant created *ad hoc*, or the superintendent of the hospital, if distinct from the medical officer of health, should place his services at the disposal of neighbouring practitioners for purposes of consultation in doubtful cases; and the other, that the isolation accommodation of the hospitals should be largely increased, so that all cases presenting any doubt could be sent in for observation till an accurate diagnosis could be made. Now it depends largely on the view that is taken as to the function of isolation hospitals whether or not these proposals meet with approval. If it is held that all cases of the notifiable diseases should be isolated early and completely, then it seems certain that such isolation can only be carried out to the advantage of the public and without detriment to the patient by the provision of a large margin of single-bedded wards into which doubtful cases can be admitted for leisurely observation and prompt treatment. Under present conditions a doctor who is careful of his reputation is loth to sign up a patient till the symptoms and signs are well established. In the case of enteric fever this means a delay which is highly disadvantageous to the patient if he is to be subsequently moved, and in the case of diphtheria valuable time in giving antitoxin may be lost. The proposal that an official of the Health Department should be available for consultation with private practitioners in doubtful cases was not well received by the meeting; chiefly on the ground of practicability. For our own part we are certainly inclined to favour it, both from the side of the patient and the practitioner. In doubtful cases a private doctor takes on his shoulders a considerable responsibility in certifying, because not only may his diagnosis be upset when reviewed in hospital, but the patient's friends when they become aware of the fact are apt to circulate the intelligence to the practitioner's grave detriment. The medical officer of health, although under prevailing conditions in London and large towns he tends to become less of a physician and more of a man of affairs every year, is a public official whose livelihood does not depend on his reputation for clinical perspicacity, and his concurrence in the removal of a patient to hospital would relieve the doctor in attendance of the odium attached to a mistake that is often unavoidable. Of course the medical officer of health should only examine the patient when requested by the private attendant, but his confirmatory opinion in the case of patients unable to pay for special advice would strengthen the practitioner's hand considerably, and would put things on a more satisfactory footing.

SYPHILIS AND THE SPIROCHÆTE.

It is not only the scores of workers who have been endeavouring to verify Schaudinn's researches into the causation of syphilis by independent investigation who will be grateful to him for the further account of his experiments recently published. To them his paper will be invaluable, while to the much wider circle of medical men and the public who now, at last, hope to see light where only darkness was, it gives plain information and holds out an encouraging prospect. The actual state of affairs is very simple, and can be expressed in a few sentences. In an enormous number of case of primary and secondary syphilis, a distinctive organism, called by Schaudinn the *Spirochæte pallida*, has been observed, not only by its discoverers, but by over a hundred other bacteriologists, including, to mention no less notable names, Roux and Metchnikoff. It has also been found in the syphilitic lesions of the apes inoculated by the last-named observers at the Pasteur Institute. It has never been found in non-syphilitic lesions. Moreover, the occasional failures to find it in syphilitic lesions can generally be explained as due to faulty technique, as in all Schaudinn's later cases—up to seventy in number—he had found it without a single failure. These facts are certainly sufficient to give a strong presumption of a causal connection between the organism and the disease, though, of course, we are still far from establishing a proof sufficient to satisfy Koch's postulates. In the absence of any method of growing the organism *in vitro*, it is indeed impossible to satisfy them, but it is not to be forgotten that in the case of many diseases, as, for example, leprosy, there is no practical doubt as to the causal organism, although it has never been cultivated. The technique of demonstration of the *Spirochæte pallida* is so simple that it can be practised by anyone of ordinary skill in bacteriological methods, though it requires some experience to distinguish with accuracy between it and other somewhat similar organisms. Schaudinn recommends the use of Giemsa's stain, a special modification of Romanowske's eosin and methylene blue combination, purchasable from dealers, as giving the most distinctive appearance, but the organism can be demonstrated with the ordinary Gram's solution of gentian violet, or can be seen in a hanging drop preparation. All that is necessary is to take a few drops of exudate from a primary or secondary lesion—chancre, bubo, papule, or other manifestation—and examine them by one of the above methods. Confusion may arise between the *Spirochæte pallida* and other spirochætæ often found in ulcers, but the former is distinguished by the pale hue adopted when treated by Giemsa's stain, and by the fact that its curves are much closer together and more corkscrew-like than those of other spirochætæ. More minute differences are observable by special methods, and Schaudinn has shown that the *Spirochæte pallida* owes its motility to the possession of terminal flagella, while most other spirochætæ are unpossessed of flagella, but have an undulatory membrane. We look eagerly for further information on the subject both from Schaudinn and from the scores of observers stimulated by him. At present it must be admitted that while the causal connection of the organism with syphilis is not fully established, its presence in any doubtful case is, at the least, a point to be borne in mind in diagnosis.

FOREIGN BODIES IN THE ŒSOPHAGUS.

The recent death of a lady doctor in the North of England as the result of perforation of the œsophagus by a foreign body has brought that accident into prominence. The facts of the case were simple. The lady unfortunately swallowed in some mutton broth a spicule of bone which lodged in the gullet. A few hours later she consulted one of the leading surgeons of the town in which she resided. No foreign body could be seen or felt, but the patient vomited as the result of the examination, and later, on the advice of the surgeon, went into hospital. That same evening the surgeon passed a coin-catcher and located the bone near the stomach. As the pain later grew more intense, an anæsthetic was administered, and vomiting again occurred. Within twenty-four hours the patient died with signs of pneumothorax and collapsed lung. *Post-mortem* a rent of one inch in length was found in the pleuron, extending from a rent three inches long in an inflamed œsophagus. The question raised at the inquest was whether the fatal perforation resulted from penetration of the bone alone, from the agency of the coin-catcher, or from the vomiting. The precise truth can never be ascertained, but in any case the surgeon in charge of the case, a most skilful and conscientious man, must be absolved from any suspicion of not having done all that was humanly possible to rescue the unhappy sufferer from the results of her perilous accident. At the same time, the questions involved are of the utmost practical importance to medical men. At the outset it may be remarked that the introduction of the modern methods of radioscopy and of œsophagoscopy have placed the diagnosis and treatment of foreign bodies in the œsophagus on a greatly improved footing. No great general hospital could be considered fully equipped for such emergencies unless provided with means for carrying out both methods of investigation. The great virtue of the Röntgen rays is that they enable the surgeon to locate the foreign body without difficult and dangerous instrumental explorations. In dealing with a sharp spicule of bone it is clear that the risk of per foration must be overwhelming upon contact with an instrument, no matter how delicately or skilfully handled. In a recent issue of THE MEDICAL PRESS AND CIRCULAR (October 4th) an able article appeared from the pen of Dr. Berard, of Lyons, under the title, "How to Deal with Foreign Bodies in the Œsophagus of the Child." On account of the attendant risk he deprecates "exploration of the œsophagus by bougies and probangs whenever the diagnosis can be arrived at in any other way. Certain it is that the passage of a sound, and more particularly of a probang, is often dangerous, and frequently useless. Even comparatively large bodies may escape the grasp of the instrument; in short, the method is one which ought to be left to practitioners living in remote parts of the country where skiagraphy is not available. In any case, the instrument should be introduced with great gentleness, and as soon as the site of the object has been determined no further attempt at introduction should be made. The only safe and sure means of making the diagnosis is by skiagraphy, and by the aid of the œsophagoscope." Having established the nature and exact situation of the foreign body, the next question to be settled is the best means of extraction. In the upper part the object can sometimes be grasped by forceps, but they should, if possible, always be under control of the finger. Fergusson's umbrella, commonly used by British surgeons, is a good instrument for use with coins and other rounded objects. In Germany brilliant results are often obtained by removal through the œsophagoscope, for the use of which an anæsthetic is necessary. Dr. Berard condemns the use of Graefe's basket unhesitatingly. His chief point is to insist upon the desirability of external œsophagotomy, which, he says, is far simpler and less dangerous than is generally believed. In the best hands operation performed under the peculiar circumstances of the case must necessarily be attended by a high mortality. The proportionate rate, however, is apparent rather than real if we bear in mind the precarious state of the patients at a time when prompt surgical interference often presents the only hope of recovery. When the foreign body is impacted low down in the œsophagus, beyond the reach of external œsophagotomy, the difficulty of meeting the danger becomes proportionately increased. In such a case as that previously noticed, the only chance of saving life would probably have been the prompt removal of the bone by opening the stomach and exploring the lower end of the œsophagus. It is easy to be wise after the event, and we can understand the hesitancy of a surgeon in subjecting a patient to the risks of so grave an operation if there were any possibility of its avoidance. Sharp spicules of mutton-bone in the œsophagus, however, do not warrant either hesitancy or delay, any more than they are distinctly unfavourable for any instrumental exploration of the œsophageal tube. Considering the many hard foreign bodies that are swallowed, both by intention and by accident, it is remarkable that lodgments in the gullet are not of more frequent occurrence. When the emergency occurs, it demands full knowledge and promptness of action on the part of the medical man, whether he be general practitioner or operating surgeon. It is safe to say that the reputation of a medical man may be made or marred at any moment by this method of dealing with an impacted foreign body in the œsophagus.

Notes on Current Topics.

Vitality of the Tubercle Bacillus in Sputum.

FOR many years investigators have studied the subject of the length of life of the tubercle bacillus outside the human body. As the bacillus is a strictly parasitic one, and is unable to multiply when cast off in discharges, the question resolves itself into that of the vitality of the individual bacillus. It is generally known that dried sputum retains its infectivity in some cases for several months, though its virulence probably undergoes a gradual diminution. Sunlight was shown by Koch to have a destructive effect on the bacillus, and his results have been confirmed by Ransom, Delépine, and many others. Sewizky, on the contrary, found that sputum subjected to the ordinary conditions of the floors of a dwelling-house preserved its virulence for over two months, and no difference was noted between the sputum which had been exposed to light and air, and that which had been hidden in dark corners. Quite recently Dr. Twichell, of Saranac, has made extensive experiments which make more clear the conditions which govern the vitality of the bacillus whilst outside the body. His conclusions show that the direct rays of sun kill the organism in a few hours. On the other hand, darkness and moisture tend to the prolongation of its life, bacilli kept under such conditions having been found infective at the end of five months. Ordinary room temperature, too, is more favourable to the bacillus than a temperature a little higher or a little lower.

Neck-Breaking Extraordinary.

A WONDERFUL story is told in the *Irish Independent* for October 25th, which may or may not be believed, according as their readers' dispositions are credulous or critical. It is asserted that a man named Pape, who began life as a high diver at circuses, had the bad fortune to break his neck, and the good fortune to recover from his injury. But, though his life was spared, he found that he possessed the rare faculty of dislocating his neck at will, the seat of election being between the fourth and fifth cervical vertebræ. Little recking of the potentialities of this acquirement, he continued to lead the life of a straightforward citizen, till one day he fell off a tramcar and was taken unconscious to hospital. When he came to his senses he found himself in bed with extension applied to his head and lower limbs, and as he ruminated on his strange situation a visitor, in the shape of a "claim-adjuster," arrived on behalf of the tram company to offer compensation for his injury. Realising that the doctors had mistaken his old lesion for a fresh one, the complacent Pape agreed to settle at £20, and life promptly assumed new possibilities for him. A solicitor was consulted on the law of liabilities as pertaining to tram companies, and adventurers were suborned to act as witnesses. Another tram-car accident was stage-managed, and with the help of his new friends the ex-diver continued to extort £12 from the company. However, as he could not break his neck too often in the same town, he took to touring, and for a long time maintained himself and his witnesses by a succession of neck-breaking exploits. Eventually he was discovered by the police, and, together with his gang, placed out of the immediate reach of tramcars and lawyers. We should be more satisfied with the story if the details as to time and place were a little more circumstantial, and still more so if certain anatomical improbabilities were cleared up. From the diagram which the *Irish Independent* gives to explain the mechanism of the dislocation we fail to glean much convincing information, except that Pape differed from his fellow-mammalia by possessing but five cervical vertebræ, and that he was apparently able to use this essential part of his anatomy much as a coster manages the bellows of a concertina.

Sir Thomas Browne.

The reputation of Sir Thomas Browne still seems to be somewhat sore from the criticisms to which it was subjected last year at the hands of Dr. Conolly Norman, who appeared in the *role* of *advocatus diaboli* at the great writer's canonisation. At any rate, many of those who took public part in the recent tercentenary celebrations found it necessary to attempt excuses for the unfortunate incident of Browne's evidence against the women accused of witchcraft, on which Dr. Norman's strictures were based. We think it might be well to let the incident sink into oblivion, since it seems to be an instance of that facing-both-ways attitude which was undoubtedly Browne's chief weakness, and surely Browne is a sufficiently great man to be permitted to have a weakness or two. The special pride felt by the medical profession in Sir Thomas Browne is fully justified when it is remembered that the name of no other veritable practising physician is to be found writ so large in the roll of English literature. It is true that there are medical men such as Goldsmith and Keats, whose names stand higher as writers, but their connection with medicine is nominal rather than real. Browne, moreover, did much to raise the dignity of the medical profession in England by his own unquestionable high character and high position. Although many extravagant things have been said about Browne during the past few weeks, it is mere truism to admit that as a master of style he stands supreme, and as long as the English language is read his position is secure.

Newspaper Retinoscopy.

A discovery which is rightly characterised as astounding is related by the Rome correspondent of the *Daily Chronicle*. He relates that Professor Cyprian Martini, "the celebrated Roman ophthalmologist," having invented an improved ophthalmoscope, obtained permission to use it to examine the eyes of a young student named Casale, who is charged on his own confession with the murder of Signor Bianchi. How long after the murder the examination was made is not stated, but it is evident from the details given that some days must have elapsed, and the fact is mentioned that Casale has been tormented by the dead man's image since the date of the outrage. At any rate, Professor Martini affirms that he discovered a perfect profile of the murdered man "at the back of the retina" of Casale's right eye, so clear that he was able to discover the exact expression of Signor Bianchi's face at the moment of the assassination. No impression was visible "at the back of the retina" of the left eye, so the professor concludes that the murder approached his victim from the side and cut his neck with a razor. These extraordinary allegations have opened up columns of "learned" discussion in the Italian press, and confirmatory evidence is alleged to have been supplied by the writings of medical men. The whole story will not stand a moment's criticism. That a medical expert who obtained a piece of damning evidence against a man charged with murder should communicate the fact to the press would, we believe, be as impossible in Italy as it would in this country, and if any statements of the kind mentioned have been made they can only be ascribed to an elaborate practical joke. We have yet to see the "improved" ophthalmoscope that can see photographs of men's faces on the human retina, or the retina that can retain images for several days; or the man, who has two sound eyes, who uses monocular vision for looking at murderers. The whole story can be dismissed as a trumpery myth.

Summer Diarrhœa.

The group of diseases known as summer diarrhœa is becoming year by year more important, at any rate, in the United States of America, since year by year it figures more largely in the mortality returns. It is important to notice that summer diarrhœa is not one disease, nor does it exclusively occur in the summer, but the name is applied to several conditions of very varied etiology, most of them occurring with greater frequency in the summer than at other times of the year. Dr. C. W. Dunin, from an analysis of several hundred cases occurring at one of the infant hospitals in New York, has been able to distinguish five separate conditions known under the common term. Of these by far the most common are the fermentative form, or green diarrhœa, and the infectious form. The cause of most of the latter is the bacillus of dysentery, though it is not unlikely that other bacteria may give rise to similar conditions. In diarrhœa due to the bacillus of dysentery there are definite signs of ileo-colitis, blood and mucus in the discharges, and fever.

Meckel's Diverticulum.

Meckel's diverticulum is usually regarded as a fœtal remnant of little practical importance, and of no interest except to the anatomist and the embryologist. That, however, it may prove a factor of importance in the production of various abdominal crises is shown by the long list of pathological conditions due to its presence, tabulated by Dr. Miles Porter, of Fort Wayne (*a*). In his opinion Meckel's diverticulum is a greater danger to life than the vermiform appendix, and the conditions he enumerates are sufficient to justify the opinion. In more than half the cases collected the diverticulum acted as a band, causing acute obstruction of the bowel, while in others it led to volvulus or intussusception. In a small number of cases the diverticulum itself was the seat of a diseased condition, such as inflammation, typhoid perforation or tuberculous ulceration. The diagnosis of course is difficult to make, and in only one of the 184 cases collected was the diagnosis made before operation. In some cases the symptoms closely resembled those resulting from disease of the appendix. Dr. Porter is of opinion that in every laparotomy search should be made for the diverticulum, and if it be present it should be removed.

The Government and Vitality.

One of Mr. W. W. Jacobs' delightful characters, who feared that his length of days might shortly be curtailed, was reassured by his comrade explaining that such an end was preferable to "laying long." The present Government has falsified the prognoses of the Opposition journals so persistently that, were it not for the speech of Lord Londonderry at Sunderland on the 1st of this month, one might be led to believe that the process of "laying long" was likely to stretch out indefinitely. However, the President of the Board of Education announced fairly definitely that his colleagues and himself were resigned to their inevitable fate, a passing to which the term euthanasia would but ineptly apply. The reasons why Ministers have "clung to office" have been variously conjectured at, but it has remained for Mr. Brodrick to lift the curtain and let us into the Cabinet secret. Speaking at Godalming, the Secretary for India explained that in America, where one year in every four is spent in electioneering, the vitality of the people is subjected to a severe strain, and that this tax on their energy is reflected in their life statistics, "which were proportionately lower than ours." It was important, said he, to keep our Government stable. The cat, then, is out of the bag. No regard for political expediency weighs with the Cabinet in retaining office, nor are they influenced by considerations of foreign policy, as has been foolishly alleged; the real reason is a regard for the national health, and a fear lest the vital statistics should (like foreign exports) decline. Medical men are glad to accept hygienic doles from whichever side they are offered, but we fear that they are not all prepared to sink their opinions on Imperial politics in favour of public health legislation. In future, let them be magnanimous and take a lesson from the self-restraint of the Government.

London Lunacy.

The report of the Asylums Committee of the London County Council for the twelve months ending in March last has just been published, and it is reassuring to read that the admissions for the year have fallen considerably. For 1903-4 the figures were 4,502; for 1904-5, only 3,813. There is still an increase in the total numbers under treatment, but that the ratio of increase is smaller is shown by the appended table:—

Year.	Total under Treatment.	Increase.
1902	22,155	786
1903	22,952	797
1904	23,948	996
1905	24,652	704

From these figures it will be seen that the increase for the past year has been less than that for any year since 1901, a fact which is particularly significant in view of a slight falling off in the numbers discharged. These features, it may be remembered, were stated in the last report of the Lunacy Commissioners to be characteristic of the country as a whole for the last twelve months, and to those who are inclined to attribute too much influence in the production of lunacy to urban conditions of existence, they will act as a check. It is far too early yet to be able to generalise, but it may be hoped that the high-water mark in lunacy has been reached, and that although no great fall may be expected, yet the asylum population will not continue to grow out of proportion to the general population. Undoubtedly much of the increase in lunacy is apparent merely, and is due to better diagnosis on the part of the profession and less reluctance to certification on the part of patients and their friends. It may, therefore, be hopefully anticipated that the effect of these factors has now reached its maximum, and that a normal level for lunacy has been reached.

The Troutbeck-Freyberger Inquiry.

Medical men generally will be interested to see that the legality of the methods followed by Mr. Troutbeck, the Coroner for the City of Westminster and for South-West London, is being made the subject of inquiry before Mr. Cockerton, the Local Government Board auditor, who deals with the London County Council accounts. As the case is still *sub judice*, it would be improper to offer comments on the merits of a question about which doctors all over the country have been kept pretty

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(*a*) Journ. of the Amer. Med. Assoc., September 23, 1905.

well informed for the last two or three years. The parties to the inquiry are the British Medical Association, which is represented by Mr. Bodkin, and the County Council, which is represented by Mr. Ryde, and the point at issue is whether the fees arising out of Mr. Troutbeck's practice of employing Dr. Freyberger to make *post-mortem* examinations on nearly all the cases in his district which are examined pathologically are legally paid or not. It appears that the County Council furnished the Coroners with a list of eighteen pathologists who were prepared to undertake the work in cases when special experience was required, but that during the period of twenty-two months under notice in all but half a dozen out of 862 inquests in which pathologists were engaged Dr. Freyberger was employed, and that always in Mr. Troutbeck's district. During the last year £1,098 had been paid to Dr. Freyberger in fees, and during the twenty-two months £1,767. Mr. Bodkin contended that the rates had been unduly weighted by the practice of Mr. Troutbeck, and that the statutory rights of the medical practitioners who had attended during life the persons on whom the inquests were held had been ignored. Mr. Bodkin dealt with certain statements made by Mr. Troutbeck as to England being the only civilised country where pathologists were not called, and the public funds not being supposed to be thrown about in order to assist medical men. He raised laughter by observing that the public funds were being thrown about to assist one medical man in defiance of the law and at the expense of the ratepayers. After Mr. Ryde had submitted that all the auditor could decide was whether Dr. Frevberger had been paid his fees rightly or wrongly, the inquiry was adjourned for three weeks.

St George's Hospital, London.

LIKE the rest of the London medical schools, St. George's is feeling the stress of outside competition. An excellent medical education and a degree on reasonable terms are nowadays attainable in various provincial centres. The St. George's Hospital authorities have acted wisely at this juncture in issuing a pamphlet setting forth the claims upon public support of their institution, which was founded two centuries ago. The name of one of their surgeons, John Hunter, the founder of modern scientific surgery, is alone sufficient to render St. George's memorable for ever in the annals of mankind. Jenner, again, the immortal discoverer of vaccination, was a student at St. George's, under Hunter. Other famous men connected with the hospital include Cheselden, Cæsar Hawkins, Sir Benjamin Brodie, Sir Henry Acland, and many more. The pamphlet spoken of above is published under the title of "The Nation's Debt." It is a most able and well-informed literary publication. As a matter of fact, it is a masterly plea for the endowment of medical education in general and of the St. George's Hospital Medical School in particular. Such details as the endowment of the study of disease; the payment of teachers who do not practise, and the endowment of post-graduate teaching, are briefly but clearly discussed. Apart from its immediate object, this little pamphlet deserves the widest circulation if only on account of its educational value to the community upon a somewhat neglected point in social economics.

National Sanatoria for Tuberculosis.

THE National Association for the Establishment of Consumptive Sanatoria for the Working Classes is making a strong appeal for public support. On November 18th, a meeting is to be held at the Memorial Hall, Farringdon Street, London, E.C., under the Presidency of H.R.H. Princess Christian of Schleswig-Holstein. A special effort is being made to engage the interest and support of the Friendly Societies and kindred bodies. This attempt in the direction of self-help is much to be commended. The fact that Mr. W. G. Bunn, the well-known and most successful Secretary of the London Hospital Saturday Fund, is also acting as Secretary of the Executive of the Association probably to no small extent accounts for the breadth and practical nature of the organisation. The point of the legal power of Friendly Societies to subscribe to such an undertaking is discussed. The general conclusion is that beyond a doubt they possess legal powers to engage in such work. That a real need exists is shown by the fact that in 1903, out of 2,053 deaths among members of the Hearts of Oak Benefit Society, no less than 361 died from consumption; 742 died under forty years of age, and of these 207 (or 28 per cent.) died from tuberculosis at the most valuable period of their life. Yet this "great white plague" is absolutely preventable.

The British Science Guild.

THE objects of the recently founded British Science Guild are admirable. Their main guiding principle appears to be the application of the truly scientific spirit, "essential to all true progress," to mundane affairs in general. The patient scientific spirit which makes the discovery of truth its end and aim is clearly the only one that can ultimately rule the world. Indeed, the whole progress of mankind is due to the discovery of the underlying facts and natural laws of this complex environment. So far as medicine is concerned, the field of research is almost as illimitable as the means are inadequate. If, therefore, the British Guild be able to educate public opinion upon the necessity of endowing medical science it will earn the gratitude not only of the medical profession but also of the community which would ultimately profit by these works. The idea has evidently appealed to many great minds, for on the printed list of supporters we find the names of many men distinguished in science, art, politics, and other fields of social activity.

"A Short Dictionary of Physiology."

UNDER the above heading is published a contribution to the new "Harmsworth Educator," the first part of which has just appeared. This work is described as "the only one which tells you all you need to know"—and yet in the "Short Dictionary of Physiology" one reads that the fibula is "the smaller bone on the inner (*sic*) side of the lower leg." Personally, we have never heard of the expression "lower" leg before, nor have we learned that the new physiology teaches that the fibula is on the inner side of the leg. Again, the cæcum is described as "a blind tube in intestines" (*sic*); while the appendix is "a blind tube extending from the cæcum." The degree of blindness in this region possibly affords an explanation of the blundering way in which the appendix frequently becomes inflamed. Furthermore, we learn that a "nerve fibre" is "the thread extending from a nervecell." As, however, all semptresses know, threads are of various kinds and makes, and each bears a number. But we have hitherto been unaware that any kind of thread was ever normally present in the human body. A molar is described as a "permanent cheek tooth" (*sic*). Whatever does the compiler mean? Every popular dictionary explains that a molar tooth is so called because of its "grinding" capacities. Again, it is instructive to note that extraordinary statement that the ovary is "the female sexual organ containing eggs." This dictionary is described as "short." It might have been shorter. We know not by whom it was compiled, but we can scarcely believe that any medical man could have had a hand in it. The proper way to teach science to the populace is not by slipshod inaccuracy and ambiguity of definition, but, on the other hand, by endeavouring to raise, stimulate, and inform their intelligence so to place the elements of science before them in terms which, while simple, are none the less precise and accurate.

Journalism Rampant.

SOME time ago we commiserated with Dr. C. W. Suckling on the unpleasing notoriety thrust upon him by certain local newspapers. Birmingham editors, however, have not ceased their attentions, in spite of the notice that their victim cannot have failed to convey to them as to its grossly offensive nature. Their latest outrage is simply appalling. Dr. Suckling recently published a short book on movable kidney. The chief offenders are the *Birmingham Gazette and Express* and the London *Express*, which devote whole columns to the description of a "Great Medical Discovery" by a Birmingham Physician. Dr. Suckling is hailed as the inspired discoverer of the condition, which, however, was clearly described by Dietl in 1864. The point that seems to have roused special attention is Dr. Suckling's suggestion that floating kidney may in some instances be the cause of mental disorder. Now, every normal kidney moves, and is always moving, more or less, but it is hardly common to find any great range of displacement that might merit the description of "movable" or "floating." Many cases exist only in the imagination of the physician or of the patient. It is a diagnosis in which it is emphatically wise to take more opinions than one, especially when operation is advised. We regret to note that Dr. Suckling has been drawn into a public newspaper correspondence with Dr. Forbes Winslow upon his theory. That cannot mend matters. If a deliberate scientific verdict be required there is abundant evidence at hand in the enormous mass of *post-mortem* results carefully kept in all our best asylums. It is hardly likely that any constant connection between movable kidneys and insanity could have escaped attention. Our heartfelt sympathy must be with Dr. Suckling in his persecution. If he gave notice to the editors on a former similar occasion to discontinue their unwelcome notices, it is conceivable that he would now have ground for legal action. The seriousness of the affair is apparent when Dr. Suckling has to write letters to the newspapers denying certain rumours among his medical brethren that he sent his book to the public journals for notice, and that he wrote the review himself. Unfortunately, an authority upon medical ethics, published by Dr. Saundby, of Birmingham, does not deal with this particularly offensive form of annoyance. Still, the Medical Defence unions might be consulted.

PERSONAL.

H.M. QUEEN ALEXANDRA has subscribed £100, and King Edward £50 to the Finsen Memorial to be erected in Copenhagen.

H.R.H. THE PRINCE OF WALES has graciously signified his Royal Highness's approval of the appeal to raise an Endowment Fund for St. George's Medical School by sending a donation of £100.

THE supporters of the present Parliamentary representative of the Edinburgh and St. Andrews Universities, are urging the claims of Sir John Batty Tuke, M.D., M.P., to a continued tenure of that important position. Sir John is Unionist in politics, and on the fiscal question supports the Prime Minister.

THE Liberals of the Edinburgh and St. Andrews Universities, on the other hand, are giving their support to Mr. J. St. Loe Strachey, editor of the *Spectator*, who, although Unionist in politics, has for some years past carried on a vigorous crusade against Mr. Chamberlain's Protection policy.

MR. C. W. MACGILLIVRAY has succeeded Sir Patrick Heron Watson as President of the Royal College of Surgeons of Edinburgh.

THE first general meeting of the Zoological Society of London will be held at 3, Hanover Square, on Tuesday, November 14th, at 8.30 p.m. Dr. Walter Kidd will read a paper on the papillary ridges in mammals, chiefly primates.

THE Society of Anæsthetists held its annual dinner at the Imperial Restaurant on October 20th, under the chairmanship of the President of the Society, Dr. Edgar Willett.

The French Congress of Medicine will hold its ninth meeting in Paris in 1907, under the presidency of Professor Debove. The General Secretary is Dr. Bezançon. The following are proposed for discussion: (1) The part played by the thyroid body in pathological anatomy; (2) hæmophilia; (3) treatment of ulcer of the stomach.

At the fourteenth annual meeting of the Association of Military Surgeons of the United States, held at Detroit, Maj. Jefferson Randolph Kean, U.S. Army, was announced to be the winner of the Seaman prize for 1905 of 500 dollars offered for the best essay on "The Prevention of Disease in the Army, and the Best Method of Accomplishing That Result."

H.R.H. Princess Christian of Schleswig-Holstein will preside at the meeting of the National Association for the Establishment of Sanatoria for Consumptive Workers, to be held at the Memorial Hall, Farringdon Street, London, E.C., at 5 p.m., on November 18th.

Amid considerable excitement Mr. Haldane was, on Saturday last, the 4th instant, elected Lord Rector of the University of Edinburgh, beating the Conservative candidate, Lord Linlithgow, by a small majority.

On the same day, Saturday last, another Liberal was elected Lord Rector of the University of Glasgow, in the person of Mr. Asquith, who thereby defeated Lord Dunedin.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

Sir Frederick Treves on "Medicine a la Mode."—An Edinburgh audience had the privilege this week of hearing Sir Frederick Treves expound what the chairman, Lord Rosebery, described as a philosophy of medicine, and the lecturer himself a *Religio Medici*. The creed and dogma of this (by no means new) religion were that disease, as popularly realised in the symptoms to which bacterial invasion, etc., give rise, was not one of the ills that flesh was heir to, but one of nature's good gifts, its motive being benevolent and protective. The first illustrative example taken was a wound in the hand with an unclean instrument, evoking local inflammation; the grumbles of the patient are quite misplaced, for the suppuration and glandular enlargement of which he complains really save him from a septic invasion. Again, common cold was due to bacterial infection; the sneezing and other disagreeables were practical measures for dislodging the organisms, the fever was the outcome of an activity aroused in the blood for the purpose of neutralising the poison engendered by the attacking host. He who grumbled at the symptoms was finding fault with a measure of relief to which he owed his life. The nature of Malta fever and plague were then glanced at by the speaker, and the process of treating diphtheria by antitoxin explained. If it were said to him that at least the machinations of cancer had no good in them, he had, at present, no answer, save that what constitutes malignant disease is known to no man, and there is little profit in being dogmatic about the unknown. It seemed that cancer reproduced, under inopportune circumstances, the type of exuberant growth which is normal and opportune when the structures of the body are being formed. If he were compelled to add to the list of pure surmises as to the possible lines on which a remedy might be found, he would suggest the trial of thymus extract, the gland being one which wastes after the period of greatest bodily activity is over, and which might therefore exert the influence late in life which it exerts when growth is alert in the young. Sir Frederick Treves' address was listened to by a crowded audience, among whom were many medical men, and was awarded a hearty vote of thanks on the motion of Sir William Turner. As a religion, his creed may be a good practical guide-book to the public and the profession; as a philosophy it covers but a small part of medicine; nevertheless, the Philosophical Institution should be grateful to the distinguished surgeon for travelling four hundred miles to lay his views before its members.

Edinburgh University Rectorial Election.—Polling for the Lord Rector took place on November 4th, when the Liberals, for the first time for a quarter of a century, snatched a hard-won victory from their opponents. The proceedings were characterised by the good-natured horseplay which traditionally clings round rectorial elections, and to the casual observers it seemed that more blue, ochre, red lead and flour and soot were in evidence than usual, while the more prominent electors had assumed a distinctly polychromatic appearance by the time they recorded their votes. It was also observable that an unusually large number of women students took part in the election, and, judging solely from the favours worn by them, about two-thirds or more of the fair sex appear to have supported the Liberal candidate. On any but political grounds it would be difficult to say whether Lord Dunedin, the Lord Justice General, better known outside Scotland, perhaps, as Mr. Graham Murray, Scottish Secretary, or Mr. R. B. Haldane, M.P., is a more suitable Lord Rector, and as the figures show, the contest was a close one—Haldane, 877; Dunedin, 847.

Parliamentary Representation of Edinburgh and St. Andrews Universities.—Mr. J. St. Loe Strachey, the Free Trade candidate, has issued his election address to the electors. It is unnecessary to quote this document, for, as proprietor and editor of the *Spectator*, Mr. Strachey's political views are sufficiently well known to all. Sir John Batty Tuke has not issued an address, but a circular has been sent out on his behalf regarding the organisation of a general committee. The issues between the two candidates are thus perfectly clear. Mr. Strachey, as a Free-Trader; Sir John Tuke, a Protectionist, or, at least, a follower of Mr. Balfour, beyond whose policy he does not go. Sir John Tuke has also in his favour an intimate knowledge of the University needs, and a genuine interest in the welfare of the medical profession. No one as yet has ever ventured to guess how the election (as Mr. Chamberlain says, "ever receding into the background") may ultimately go. With so scattered a constituency, and one which may decide to vote on either purely party lines or on grounds of University needs, prophecy is quite impossible.

GLASGOW.

The Miserable Stipends of Hospital Medical Officers.—One of the Glasgow newspapers a few days ago, in referring to an advertisement for a "senior medical assistant" for Stothill Hospital, the largest of the various parish hospitals, and where the salary offered is £150, with board, &c., makes the following pregnant remarks. It says that, "Considering that the position involves the care of about 1,700 inmates, the figure cannot be said to be wildly extravagant." Considering the enormous cost of the hospital, the responsibility of the office advertised, with the heavy duties attached thereto, the salary offered is totally inadequate and niggardly in the extreme. It may be useful information to the members of the Glasgow Parish Council to be told that young medical men, or graduates fresh from the University, can readily get engagements as *locum tenens* at £4 4s. to £5 5s. per week, and so assistants to general practitioners can command a higher rate of remuneration for their services than that offered by them. We trust that this important and responsible corporate body will, in giving this matter further consideration, display a more magnanimous spirit.

Glasgow Medico-Chirurgical Society.—At a largely-attended meeting of this Society, held in the

Faculty Hall on Friday, the 3rd inst., Mr. H. Sampson Handley, F.R.C.S., &c., Hunterian Professor, Royal College of Surgeons, England, gave an interesting address on "The Mode of Spread of Breast Cancer, with special reference to operative treatment." It was illustrated by means of the lantern, many beautiful slides being shown of sections of skin where the estrangement of cancer nodules were clearly indicated, and also showing how the cancer cells are conveyed by means of the lymphatics, rather than by way of the blood stream, although he acknowledged that such a path of infection is quite possible, and probably does take place occasionally. In the removal of the breast for cancer he advocated the circular incision round the breast, with a straight one from the margin of the axilla and another straight incision below the breast extending as far as the epigastric area, altogether an incision about ten inches in length. He also laid considerable stress on the need for removal of the deep fascia well away from the diseased structure. This, by the mobility of the flaps, prevents the tension which often occurs after the ordinary operation, and is a decided advantage. In the discussion which followed Sir Hector Cameron, Dr. Renton, Mr. Pringle and others took part. On the motion of the president, Dr. Lindsay Steven, a hearty vote of thanks was accorded Mr. Handley for his address, which was listened to very attentively, and was much appreciated by a large audience drawn from the various medical societies.

Dr. Gibson, of Campbeltown.—A short time ago we referred to the jubilee of Dr. Gibson, on which occasion he was the recipient of a very substantial public testimonial. Now he has just received the congratulations of the Parish Council through its chairman on the completion of fifty years' service as parochial medical officer. The Council state that his is "a record of public official service not often approached, and which he still continues with vigour and efficiency." Such expressions of appreciation of his long public services must be very pleasing and encouarging to Dr. Gibson.

BELFAST.

Royal University Graduates' Association.—This Association, which has apparently been dormant since the death of its founder and president, Dr. W. A. McKeown nearly a year and a half ago, held a meeting in Belfast on Friday, November 3rd, and elected Dr. John Campbell as president in place of Dr. McKeown. Dr. Campbell gave an interesting address on the Irish University question. In theory, his views seem to us excellent, but from a practical standpoint must be regarded as utterly utopian. His attitude is the Unitarian one of the strongest possible objection to every form of denominational education at any and every age, and he attributes the failure of non-sectarian education in Ireland to the fact that when the Queen's University was founded to provide non-sectarian university education, Trinity College remained a centre of sectarianism. His cure is the entire separation of the divinity school from Trinity, and the union of the three Queen's Colleges with Dublin University to form a national Irish University. May we live to see it! Mr. R. W. Leslie resigned the post of secretary, and Dr. Andrew Fullerton was elected in his place.

Health of Belfast.—The report of the medical officer of health, presented at the monthly meeting of the Belfast Corporation last week, shows a death-rate of 16.6 for the past five weeks, chest affections being 3.7, and zymotic diseases 1.1. The number of cases reported under the Notification of Infectious Diseases Act was 284, including 84 typhoid and 79 scarlatina, but it is to be feared that the typhoid cases were really much in excess of those notified; probably nearer 200, to judge from the number under treatment in the fever hospital. In Belfast the householder has never been called on to notify a case in his house, as required by the Act, the whole duty being left to the medical attendant, and it is plain that in many cases there is a great reluctance to offend or trouble the patient's family by publishing the fact of there being infectious illness in the house.

Correspondence.

BELIEF IN WITCHCRAFT.

To the Editor of the Medical Press and Circular.

Sir,—The incredulity and credulity of the masses of the people in every rank of life at the present time form a phenomenon of more than common interest to the psychologist, the sociologist, and the theologian. Large sections of the public scorn science, and the scientific method.

In the domain of medicine they pin their faith exclusively to miracle-mongers, and apparently accept the claims of professors of occultism, the more eagerly often when the promises held out are most obviously impossible. Christian science, and such cults as esoteric Buddhism, number their votaries by the thousands; and these thousands are composed very largely of the wealthy, educated, and cultivated classes. Are those cults elevated in any degree above the belief in witchcraft among Irish peasants which you discuss in an editorial note today? Are they not merely a manifestation in another form of prevailing psychological conditions. How far are the phenomena due to the weakening of the authority of dogmatic theology in late years? If the edifice of religious belief is shaken and thrown down there are many natures who have no other resource than to crouch in the ruins. Within the past fortnight inquests upon two victims of Christian Science have thrown a vivid light on the concrete results which this form of miracle-mongering tends to produce. The traffic in fraudulent quack medicines goes on unchecked in spite of frequent exposure in the Civil and Criminal Law Courts. It is the rarest thing for such an exposure to produce any result beyond a stimulus towards more strenuous lying advertisement on the part of the quack medicine proprietors. Acceptance of these gross and palpable falsehoods suggests a frame of mind in which a belief in witchcraft would hardly imply any further serious degradation.

I am, Sir, yours truly,
November 1st, 1905. H. S.

Obituary.

DR. W. M. O'NEILL, OF LINCOLN.

Lincoln has lost one of its most respected citizens by the death of Dr. William O'Neill which event we regret to say occurred a few days since. Although upwards of seventy-five years of age, his death came as a shock to the people of Lincoln, as his unquestioned skill in his profession, his unfailing courtesy and high traits of character had earned him a leading place in their esteem. The heartfelt regard for the deceased held by all classes was evinced at his funeral last week, when an enormous number of floral tributes came from all parts of the United Kingdom, and a concourse of carriages and sorrowful followers on foot, such as one is accustomed to associate with a popular hero paid their last homage to his remains, and a muffled peal was rung on the bells of Lincoln Cathedral. The deceased, who had been a subscriber and a contributor to this journal for nearly half a century, was born in county Antrim in 1830, and was educated at Trinity College, Dublin, and at King's College, Aberdeen. He was a member of the Royal College of Physicians, a Fellow of the Royal Medical and Chirurgical Society of London, and a Fellow of the Academy of Medicine in Ireland.

JOSEPH KELLETT SMITH, M.R.C.S.Eng., J.P.

The death of Joseph Kellett Smith took place on October 29th, at West Kirby, at the age of seventy. He was a member of the Royal College of Surgeons of England, 1860, and a licentiate of the Royal College of Physicians, Edinburgh, 1865. He practised for many years in Liverpool, and retired from active duty in 1899, since which time he resided at West Kirby. He was one of the promoters of the Stanley Hospital, and for twenty years was honorary surgeon to that institution, and afterwards honorary consulting surgeon. In politics he was a prominent Liberal.

J. N. CREGEEN, OF LIVERPOOL.

We regret to announce the death of Dr. J. Nelson Cregeen, of Liverpool, after a long and painful illness, at the age of sixty-nine. Dr. Cregeen was well known and highly respected by a large circle of friends. He was a native of the Isle of Man, and had practised in this city for about thirty years.

MICHAEL BENNY, M.D.EDIN., M.R.C.S.E.

The death took place, on Ocotber 29th, of Dr. Michael Benny, full Surgeon-Major of the 4th Vol. Battalion A. and S.H. and Medical Officer for the burgh of Denny and Dunipace. Dr. Benny was sixty-five years of age and born in Denny, beginning practice in his native town forty-three years ago. Following upon a brilliant career at College, he established a wide connection. He was a man of the most kindly and genial disposition.

CHARLES WILLACY, L.R.C.S., L.R.C.P.EDIN.

By the sudden death of Mr. Willacy, on October 23rd, at the age of fifty-eight, Cheadle Hulme has lost not only one of its best known and respected residents, but also its oldest medical practitioner. The deceased had been in practice at Cheadle Hulme for something like 30 years. Many years ago he was a member of the Local Board, and at one time he was one of the Church officers at All Saints', Cheadle Hulme. In politics he associated himself with the Liberal party.

F. H. PARSONS, M.D.GLAS., OF WORTHING.

The death is announced of Dr. Francis Henry Parsons, of West Worthing, on Oct. 23rd. Deceased, who was sixty-eight years of age, had resided at Worthing for more than 15 years, and he was much esteemed. He was one of the Trustees of the Thomas Banting Memorial Home, on the Marine Parade. The late Dr. Parsons died, after a short illness, at St. Leonards, whither he had gone for a change, his health not having been good of late. He had not practised for many years, but was almost as well known at Hastings as he was at Worthing. He took a prominent part in promoting a successful series of health lectures at the Brassey Institute, and delivered some of them himself.

JOSEPH ORPE BROOKHOUSE, M.D.ST.AND., M.R.C.P.LOND., F.R.C.S.ENG.

We regret to announce the death of Dr. Joseph Orpe Brookhouse, one of the best-known medical practitioners in Nottingham, on October 27th, after suffering for three weeks from bronchitis. Born at Brighton seventy years ago, he succeeded to a practice in Nottingham in 1859. He took his M.D. at St. Andrews in 1862; became a member of the Royal College of Physicians, London, in 1874; member of the Royal College of Surgeons in 1857, and Fellow by Examination in 1868; and Licentiate of the Society of Apothecaries in 1857. He was senior member of the honorary medical staff of the Nottingham General Hospital, and chairman of the medical committee. He was one of the founders of the Nottingham Eye Infirmary and honorary physician of the Nottingham and Notts Sanatorium for Consumptives. By his death the medical profession of the town will be deprived of a prominent figure.

The National Canine Defence League has presented a memorial to H.M. the King, begging his influence in favour of a Bill to be re-introduced next session in Parliament for the prohibition of Vivisection of dogs. The memorial contains 644,018 signatures, over 1,000 being those of medical men. The petition with signatures measures over seven miles.

Literature.

FINDLEY ON GYNÆCOLOGICAL DIAGNOSIS. (a)

The second edition of Dr. Findley's excellent work on gynæcological diagnosis shows a considerable increase in size on the first edition, as, in addition to a thorough revision, later developments of gynæcological diagnosis have been discussed. Further, new chapters have been added upon the examination of the blood, and bacteriological examinations of secretions and discharges.

The book is divided into three parts. The first part deals with "General Diagnosis," the second with "Special Diagnosis," and the third with the "Diagnosis of Diseases of the Urinary System." In the first part, the method of case-taking is fully described; and attention is drawn to the different methods of making a diagnosi, such as are of general use in almost all cases. The second part deals with the subject of "special diagnosis," and the different pathological conditions of the genital organs are passed in review *seriatim*. Part III. deals with the diagnosis of diseases of the urinary system, and contains, among much other information, an interesting account of cystoscopy as practised with Nitze's and Pawlic's cystoscope respectively, and also of the use of a segregator.

Dr. Findley's work will, we are sure be most popular not alone with specialists, but also with the general practitioner. It is most thorough, and, save that all reference to treatment is omitted, is practically a text-book. Most of the illustrations are good, though a considerable proportion of them are old friends.

INTERNATIONAL CLINICS. (b)

This volume of the "International Clinics" contains no less than twenty-three articles on therapeutics, medicine, surgery, and the various specialities, and, as might be expected, out of such a large number only two or three are of more than ephemeral interest.

Perhaps the most valuable paper among them is that by Dr. Wiesel, of Vienna, on the "Chromaffin system" of the animal body. The term, which is comparatively new, has been applied by Kohn to the cells of the medullary portion of the suprarenal capsule, owing to the property that these cells possess of staining an intense yellow or brownish colour with salts of dichromic acid. As has long been known, the adrenal medulla is derived from cells of the sympathetic system, but Wiesel now points out that these cells do not at first possess a chromophile property, and only gradually acquire it during fœtal life, and he further points out that similar cells developed in the same manner are to be found along the entire course of the main sympathetic trunk, in the carotid body, the coccygeal body, the hypophysis cerebri, and in the glands of Zuckerkandl. There exists in fact an extensive system of cells in the body which are distinguished from all other cells by their special staining reaction. This has led to the belief that all of these cells may have some common function, a belief which is substantiated by the fact that emulsions of them, derived from parts other than the suprarenal bodies, are capable of producing the same changes in blood pressure and cardiac action as is adrenalin. The establishment of this fact must be regarded as of prime importance in demonstrating the relation that exists between structure and function, and the co-relation of widely separated organs. Wiesel also considers the pathology of the chromaffin system, especially in connection with Addison's disease, and as a result of his observations, believes that he is able to solve the problem as to why in some cases the disease exists, although the capsules are apparently intact, while in other cases, with diseased suprarenals, none of the characteristic symptoms have existed. He states, that he has found in five autopsies a universal degeneration of the chromaffin system, and regards it as the fundamental pathological lesion. It is only when a universal degeneration occurs that symptoms develop, and hence the comparative unimportance of a purely local morbidity of the adrenals, which may be accompanied by a compensatory overgrowth of the other parts of the system. Wiesel also attributes, a congenital hypoplasia of the system, the diathesis known as the *status thymicus*, but here one feels inclined to believe that the writer claims too much; indeed, the whole work, though stimulating, requires confirmation.

(a) "Diagnosis of Disease of Women. A Treatise for Students and Practitioners." By Palmer Findley, M.S., M.D., Assistant Professor of Gynæcology and Obstetrics, Rush Medical College; Assistant Gynæcologist to the Presbyterian Hospital, Chicago; &c., &c. Second Edition, revised and enlarged. Pp. xviii. and 588, with 222 illustrations in the text, and 59 plates in colours and monochrome. London: Bailliere, Tindall and Cox. 1905. Price 21s.

(b) "International Clinics." Vol. II. Fifteenth Series. Philadelphia: J. B. Lippincott Co. 1905.

Among the other papers one notes with interest the statement by Dr. Sabouraud that the X-ray treatment of ringworm has been the means of saving £75,000 to the Paris hospitals in its first year of application. Dr. Corner's paper on "Hernias" is suggestive, and contains an ingenious explanation of the natural cure of the hernias of infantile life; and the article on "Scopolanin" as a general anæsthetic, should stimulate surgeons in this country to be more enterprising in their adoption of the newer anæsthetics.

AN INDEX TO PHARMACY. (*a*)

All readers of the Year-Book of Pharmacy will welcome this General Index. By an excellent arrangement of light and heavy type the search for any given subject is much facilitated, indeed, the index doubles the value of the volume for the eighteen years with which it deals. It contains 514 double column pages; the former index for 22 years, published in 1885, had but 246 pages, so greatly have these useful annuals grown in size, and we may add both in favour and in sterling merit.

THE SCIENCE OF CAUSATION. (*b*)

This pretentious volume cannot be taken seriously. It claims to consist of "easy duologues, laying bare the hitherto hidden, and ensuring a general collapse of the foundations of materialistic science." In the form of conversation between an Empiricist and a Metaphysician there is presented a marvellous medley concerning "the causal aspects of the fundamental presuppositions of empirical science, and interpreting phenomena by the canons of the science of causation," and "religious and moral aspects of the science of causation." "The science of causation," whatever that may mean, we are assured, "ensures the intellectual collapse of empirical science" and we can well believe it. This work may afford amusement to the medical scientist.

MUCOUS MEMBRANES, NORMAL AND ABNORMAL. (*c*)

This suggestive monograph is a serious contribution to a most important physiological and pathological problem. A considerable section of the volume deals with purely anatomical considerations, but the most original portion and the part which will prove of greatest service is that devoted to the investigation of morbid conditions of the mucous membranes. Quantitative and qualitative changes are described, and it is shown that the hypomyxiatous state is often a forerunner of cancer.

There are many practical suggestions which, whatever opinion may be taken of the theoretical views so attractively presented, will be found of much service. The little volume deserves thoughtful study.

MALARIA AND INFLUENZA, DENGUE. (*a*).

No volume in Nothnagel's Practice of Medicine needs commendation to the English reader, for there are few medical men in the British Isles who have not made acquaintance, albeit in some cases only a borrowing one, with these erudite and interesting books. It is doing but bald justice to Messrs. W. B. Saunders and Co., to say that they deserve the gratitude of the English-speaking world not only for having had Nothnagel's Practice translated, but for having secured such eminent authorities to edit the volumes in their present form. The present book deals at great length with malaria and with influenza, and somewhat shortly with dengue. The article on malaria runs to five hundred pages, and is from the painstaking pen of Dr. Mannaberg. It is a great pity that it should have been written before the work of Manson, Ross, Bignami, Grassi, and Bastianelli established the role of anopheles as an infection-carrier, but this defect is to a great extent compensated for not only by Dr. Stengel's having secured the co-operation of Ross himself in the capacity of editor, but by his having obtained Dr. Stephens to write a careful and complete account of the relation of the mosquito to malaria. The article as it stands comprises practically all that is at present known about this tremendous and fascinating disease, and is illustrated by three beautiful plates of the pathological changes in the blood of malaria. We confess to some disappointment in not finding any similar plates to illustrate Dr. Stephens' article, for they would have added much to the value of the work as a complete record. A suggestive note on prophylaxis by the editor winds up the section, but we find his concluding assertion rather more sweeping than we should have expected of an old officer who has served a good part of his time in the tropics. "In a word," he says, "it is not too much to assert that the person who allows himself to contract malaria in the tropics is lacking in knowledge and in intelligence." Men may be at some time, but they are not always masters of their fates. Passing to the sections of influenza and dengue by Professor Leichtenstern we find the translation has been capably managed by Dr. Grünbaum, in spite of a good many difficulties presented by the original. The first half of the influenza article is taken up with a description of the history, epidermology, and etiology of the disease. This account is a very valuable one, and exhibits not only great care and erudition on the part of the author, but good, critical judgment in reducing garbled and exaggerated statements, contemporary and historical, to a residuum consistent with modern scientific conceptions. There is no disease about which more nonsense has been talked than influenza, and it is comforting to read a description of the disease at once sane, virile, and authoritative. The second half of the article deals with its pathology and treatment, and here we find Professor Leichtenstern unsparing in his contempt for the innumerable cures and methods of treatment which have been proposed. "There is neither a prophylactic nor a specific for influenza," says the author; and he relates with a curl of the lip the follies of people and the vogue of various drugs. It is amusing to read that in 1889, when influenza appeared, so fashionable was the craze for antipyrin as an antidote and a prophylactic that the stocks of it were exhausted, and that chemists who could no longer supply it were made the objects of hostile demonstrations. We have never read a better article on influenza than this of Professor Leichterstern's. The final section, that on dengue by the same physician, gives an acceptable resumé of what is known of this disease.

(*a*) "General Index to the Year-Book of Pharmacy, and Transactions of the British Pharmaceutical Conference for the Years 1886 to 1903, inclusive." Compiled by J. Oldham Braithwaite. London: J. and A. Churchill, 1905.

(*b*) "The New Science of Causation." By H. Croft Hillier. Pp. 386. London: Walter Scott Publishing Co., Ltd. 1905. Price 10s. net.

(*c*) "Mucous Membranes, Normal and Abnormal including Mucin and Malignancy." By Wm. Stuart-Low, F.R.C.S. Pp. 55. London: Bailliere, Tindall and Cox. 1905.

(*a*) "Malaria, Influenza, and Dengue." By Dr. Julius Mannaberg and Dr. O. Leichtenstern. Translated by Dr. Stengel. Edited by Major Ronald Ross, F.R.S., J. W. W. Stephens, M.D., and Albert S. Grunbaum, M.D. (Nothnagel's Practice of Medicine). Philadelphia: W. B. Saunders and Co. 1905. 21s. net.

MEETING OF THE GENERAL MEDICAL COUNCIL.

We are officially informed that the General Medical Council will assemble on Tuesday, November 28th, under the chairmanship of Dr. Donald MacAlister, for the customary autumn sesson, when several important matters will be brought forward for decision.

Medical News.

London School of Medicine for Women.

The following scholarships have been awarded at the London (Royal Free Hospital) School of Medicine for Women :—Entrance scholarship, £30 10s., Miss G. M. Dobrashiam ; St. Dunstan's medical exhibition, value £60 a year for three or five years, to Miss H. M. Hood-Barrs ; Mabel Webb research scholarship, value £30 a year, to Miss L. Woodcock, M.D., B.S.

Sir F. Treves on Doctors' Liberality.

Speaking at Tunbridge Wells on Nov. 3rd, Sir Frederick Treves claimed that the members of his own profession were the most liberal donors to charitable objects in the form of hospitals and other institutions for assisting the poor in times of sickness and disablement. One of the things of which English people were entitled to be most proud, he said, was that magnificent charity which had built up the famous London hospitals —a monument the like of which existed in no other part of the world.

Medical Sickness and Accident Society.

The usual monthly meeting of the Executive Committee of the Medical Sickness Annuity and Life Assurance Society was held at 429, Strand, W.C., on the 27th ult. There were present the Chairman, S. de Havilland Hall, Dr. J. Brindley James, Dr. J. W. Hunt, Dr. J. H. Dempster, Dr. G. E. Herman, Dr. Frederick S. Palmer, Dr. W. Knowsley Sibley, Mr. F. S. Edwards, Mr. Frederick Wallace, and Dr. J. B. Ball. The accounts presented showed the Society's business to be in a very satisfactory condition. A considerable skrinkage has recently taken place in the Sickness Claims list. Several members whose claims threatened to become chronic have been able to resume work, while the number of new claims received has been very moderate. The low price of securities during the last two years has enabled the Society to put out a considerable sum of surplus money at remunerative rates, and in this way to add to its financial strength. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Royal College of Surgeons, Ireland.

At the formal opening of the winter session of the school of this college, the President, Mr. Arthur Chance, delivered a short address. He said that there was a matter of which his hearers have heard so often that repetition seemed almost unwarrantable. And yet no amount of warning appeared sufficient to deter some men from drifting into a course which may possibly wreck their lives. Their brethren, he said, in the Poor-law service were still striving to obtain much-needed reforms ; and no reasonable person could doubt the moderation and justice of their claims. He therefore felt it incumbent upon him to let no opportunity pass of reminding them of their duty to the public, to their profession, and to themselves. Before applying for a Poor-law appointment they should be satisfied that the conditions are such as will permit them to efficiently perform their responsible duties towards the sick poor, that the emoluments are sufficient to enable them to occupy a position such as the humblest member of their profession is entitled to, and that their action does not weaken, or tend to render ineffective, the legitimate protests of their professional brethren. The President next referred to the inaugural address of the President of the Queen's College, Cork, in which the latter had delivered an indictment of the present University methods of this country. Mr. Chance considered that since the foundation of the Royal College of Surgeons, it had been their effort to closely associate education and examination. Out of their very limited resources they maintained a medical school. Its professors have always had a fair representation on their examining board ; and they have nearly approximated to what the President of the Queen's College, Cork, regards as the ideal system of examination—" A system under which a teacher and an external examiner work together." It was well to remember that this had been done without endowment other than money given nearly a hundred years ago—given and expended for building purposes. " Now," continued Mr Chance, " we will not lower our standard ; but I think we would do well to consider how far it is possible to extend to students of other schools the full advantages of a system of examination which theory and experience alike teach us is best calculated to secure efficient teaching and effective examination."

The President then distributed the prizes as follows : Barker Anatomical Prize : £26 5s., T. A. Burke ; Special Prize, £21, J. B. Kelly. Carmichael Scholarship : £15, R. M. Bronte. Gold and Silver Medals in Operative Surgery : Gold, J. Prendiville ; Silver, R. Bury and L. Lucas (equal). Stoney Memorial Gold Medal in Anatomy : T. Sheehy. Descriptive Anatomy, Junior : G. C. Sneyd, 1st prize and medal : R. Adams, 2nd prize and certificate. Senior : H. W. White, 1st prize and medal ; J. Murray, 2nd prize and certificate. Practical Anatomy, First Year : Miss I. M. Clarke 1st prize and medal ; C. Greer, 2nd prize and certificate. Second Year : G. S. Levis, 1st prize and medal ; G. W. Stanley, 2nd prize and certificate. Practice of Medicine—L. Lucas, 1st prize and medal ; J. Prendiville, 2nd prize and certificate. Surgery : L. Lucas, 1st prize and medal ; C. H. Wilson, 2nd prize and certificate. Midwifery : J. Prendiville, 1st prize and medal ; G. M. Loughman, 2nd prize and certificate. Physiology : A. E. S. Martin, 1st prize and medal ; G. S. Levis, 2nd prize and certificate. Chemistry : R. H. F. Taaffe, 1st prize and medal ; R. Adams and Miss I. M. Clarke (equal), 2nd prize and certificate. Pathology : G. F. Shepherd, 1st prize and medal ; C. J. Hare, 2nd prize and certificate. Physics : R. Adams, 1st prize and medal ; Miss I. M. Clarke, 2nd prize and certificate. Practical Histology : G. C. Sneyd, 1st prize and medal ; E. Harrison, 2nd prize and certificate. Practical Chemistry : Miss A. E. Nash, 1st prize and medal ; T. A. Peel, 2nd prize and certificate. Public Health and Forensic Medicine—C. J. B. Dunlop, 1st prize and medal ; W. E. M. Hitchens, 2nd prize prize and certificate. Materia Medica : C. J. B. Dunlop, 1st prize and medal ; V. J. Clifford, 2nd prize and certificate. Biology : E. A. Gregg, 1st prize and medal ; E. Harrison, 2nd prize and certificate.

The Royal University of Ireland.

A special meeting on Friday last, November 3rd, of the Standing Committee of the Senate was held by direction of the Right Hon. the Earl of Meath, K.P., Chancellor of the University, who delivered an address in which he referred at length to the riotous and disorderly conduct which took place at the recent conferring of Degrees, the Committee having resolved to take decided action in the matter, adjourned to the 7th inst.

The Senate met on Thursday, October 26th, and His Majesty's Royal Warrant appointing Mr. Charles Edward Martin, J.P., D.L., to be a member of the Senate was read. The report of the Standing Committee on the results of the recent Examinations was considered and awards made. It was resolved that the Degree of M.Ch. *Honoris Causa* should be conferred on John Stephen McArdle. There were referred to the Standing Joint Committee for report resolutions received from Convocation in reference to (*a*) Degree in Public Health ; (*b*) University, Library and Grounds ;

(c) Pension Fund; (d) the granting of an Honorary Degree. His Majesty's Royal Warrant was read empowering the Senate to admit to Matriculation Candidates who have passed such other public examination as the Senate shall from time to time decide to accept in lieu of the Matriculation Examination held by the University. It was referred to the Standing Committee to draw up details of the Examinations to be accepted in lieu of the Matriculation, the detailed regulations to be published in due course after the meeting of Senate next February. It was resolved to institute Degrees in Veterinary Medicine. It was enacted that all oral examinations in connection with the First University Examination be discontinued.

Army Medical Service.

The following has been received from the War Office:—An examination of candidates for not less than 40 commissions in the Royal Army Medical Corps will be held on January 26th, 1906, and following days. Applications to compete should be made to the Secretary, War Office, 68, Victoria Street, London, S.W., not later than January 16th, on which date the lists will be closed. Candidates who are over the regulated limit of age at the date of the examination will be permitted to deduct from their actual age any period of service in the field after October 1st, 1899, that they could reckon towards retired pay and gratuity, if such deduction will bring them within the age limit. The presence of candidates will be required in London from January 24th.

Pass Lists.

Conjoint Examination in Scotland.

The quarterly Examinations of the above) Board (Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow), held in Edinburgh, were concluded on the 2nd inst., with the following results:—

First Examination (four years' course).—Mr. Aiknath Visagee Bam.

First Examination (five years' course).—C. Jornelius O'Herlihy, Khorshed Sorabji Kanga, Vincent M. Walsh, Daniel Hickey, Thomas B. McKendrick, Edward Spence, Augustus Y. Kelsey, Harold H. Scott, Angus C. Livingston, Bertram Flack, and Robert Massie. Three passed in Physics, two in Biology, and two in Chemistry.

Second Examination (four years' course).—John S. Bruggman and Daniel J. O'Connell.

Second Examination (five years' course).—Edward R. Porter, Thomas B. Eames, Sydney Sharples, Alexander McMurray, James W. M. Hunter, John A. S. Phillips (with distinction), Anna Sarah Lindsay, Jane H. Filshill, Thirukamu S. Reddy, Vinayak S. Sanzgiri, Charles L. Stewart, Richard B. Davidson (with distinction), Byramjee S. Tarapurvalla, Alexander O'Flaherty, Frank H. Kiddle, James Reid, Francis W. Milne, David W. Anderson, and Peter Stewart. Four passed in Physiology.

Third Examination (five years' course).—Ernest F. Nivin, Gertrude E. Austin, Dennis C. McCabe-Dallas, Oliver D. Cunasekara, Alexander P. Dias, Leo Murphy, Frederick B. Elwood, John S. Peebles, John W. R. Rockwood, James Ferguson, Thomas C. Dykes, Edward A. Smith, and Ratilal R. Bakshi. Two passed in Materia Medica.

Final Examination.—Of 78 candidates entered, the following 32 passed, and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.—William G. Scott, Charles A. E. Ring, James A. Mathers, Rosa Collier, Frederick F. Middleweek, Emile H. G. Duncan, Robert P. Hosford, James Murphy, Richard G. S. Simpson, Harold S. Gettings, Sigmund Wertheim, William R. A. Coates, John Dixon, Hamish H. McIntosh, Valentine Macdonald, Norman S. Simpso [illegible]an L. Raffel, John Coffey, George D. M. Beaton, Edward E. A. Murphy, Michael P. Desmond, John K. Bell, Ernest P. Titterton, Narayam K. Desai, George L. Baker, John E. Bromley, Raghunath R. Chaubal, Thomas E. Flitcroft, Thomas F. Murphy, Kohikot V. G. Menon, Edward P. J. Dawes, and John Dawson. Eight passed in Medicine and Therapeutics, two in Surgery, and Surgical Anatomy. Twelve in Midwifery and thirteen in Medical Jurisprudence.

Royal University of Ireland.

At a recent meeting of the Senate, the following awards were made in the M.B., B.Ch., B.A.O., Degrees Examination.:—

Upper Pass.—Foster Coates, B.A., Arthur G. Cummins, James S. Dickey, James Donnelly, Rodolphus W. Harper, William Irwin, B.A., Robert S. Kennedy, James Macarthur, Campbell G. Robb, Patrick Steen, Harry C. Watson.

Pass.—James A. Beamish, Herbert W. Carson, John Devane, James Flack, David H. C. F. Given, William R. Hayden, Robert L. Keown, Andrew Leitch, James M'Closkey, Edward M. O'Neill, Thomas M. Phillips, Stephen B. Walsh, B.A., *Exempt from further examination in Medicine Group.*—James F. McDermott, Mary E. Jeremy, B.A. *Exempt from further examination in Midwifery Group.*—Mary E. Jeremy, B.A.

Honours in Medicine Group.—*First Class.*—James S. Dickey. *Second Class.*—Arthur G. Cummins, Robert S. Kennedy.

In Surgery Group.—*First Class.*—Arthur G. Cummins, Robert S. Kennedy. *Second Class.*—James S. Dickey.

In Midwifery Group.—*First Class.*—James S. Dickey. *Second Class.*—William Irwin, B.A., Robert S. Kennedy, Arthur G. Cummins, Harry C. Watson.

Exhibitions.—*First Class*, £40, James S. Dickey. *Second Class*, £25, Arthur G. Cummins.

M.D. Degree Examination.—William J. Bannister, M.B., B. Ch., B.A.O., Sydney H. G. Blakely, M.B., B.Ch., B.A.O. (awarded a gold medal for distinguished answering), Thomas H. Delany, M.B., B.Ch., B.A.O., Samuel R. Hunter, B.A., M.B., B.Ch., B.A.O., Frances E. M'Cune, B.A., M.B., B.Ch., B.A.O., Adam Moss, M.B., B.Ch., B.A.O.

The Travelling Medical Scholarship.—Isabella G. A. Ovenden, B.A., M.B., B.Ch., B.A.O.

The Medical Studentship.—The Studentship was not awarded, but Special prizes of £25 each were awarded to the following candidates:—William M'Carthy, M.B., B.Ch., B.A.O., John C. Rankin, M.B., B.Ch., B.A.O.

Conjoint Examinations in Ireland.

The following candidates have passed the Final Professional Examination of the Royal College of Physicians and the Royal College of Surgeons:—John M. Alcorn, Edmond G. Condon, Thomas W. Conway, Charles Cooper, Vincent J. Cullen, Richard F. O'Toole Dickinson, Richard F. Hayes, Miss Florence J. Lardner, Alfred C. Lewis, Thomas J. Madden, William T. Morton, Robert H. Smythe, William J. Tobin. Copies of the regulations for the Preliminary Examinations to be held during the year 1906 can now be obtained on application.

The St. John's House of Rest at Mentone is open from November 1st to May 1st, and is intended for clergy and professional laymen possessed of only small means, who under medical advice desire to winter abroad. The inclusive charge for board is 20s. a week, and the Committee are prepared to give consideration to the case of persons not able to pay this moderate sum or the railway fare to Mentone. The house is not intended for confirmed invalids, or incurables, or those who need professional nursing. Persons under the age of twenty-three and over sixty-five are ineligible Further particulars can be obtained from the Rev. W. H. Oxley, Petersham, Surrey.

Notices to Correspondents, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

PRESCRIBING OPTICIANS

F.R.C.S.—Our correspondent is quite correct. The Spectacle Makers' Company issue their diploma to opticians on the distinct understanding that it shall not be used for advertising purposes—despite which, however, the "Diplomates," as their advertisements show, sign themselves as "F.S.M.S."—whatever that may mean to the public, and so claim to be fully qualified to prescribe for all errors of refraction. We also should like to know, with our correspondent, why the "Diplomates" are allowed to advertise themselves in this manner, which is in direct contravention to the rules under which the "Diploma" is granted to them.

GENERAL PRACTITIONER.—Professor Osler has denied that his remarks concerning "the age of 40" as applied to professors were correctly reported.

JAPANESE ENTENTE.

An enterprising dealer in Shanghai, recently sent samples of "Mizu Ame" to Brompton Hospital, as a "Cure for Consumption." The label read:

"Mizu Ame. This Ame a kind of nounsing Jelly is made by the starch of rice and barley. There was verification to many prominent doctor that none such is so pure, sweet, nourish-and sanitary. jelly, specially for child and-weakening of the body. It was awarded-to silver and gold medals from the expositions. And we are so proud to advantage-to you-costumers, that it was useful by our Majestic Imperial House. Hiromiya Yamamoto. &.Co., Daikoku-machi, Nagasaki, Japan."

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 8th.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. Meeting.

SOUTH-WEST LONDON MEDICAL SOCIETY (Bolingbroke Hospital, Wandsworth Common).—8.45 p.m. Dr. G. L. Eastes: Urine—the Interpretation of its Analytical Results.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus).—8.30 p.m. Pathological Evening.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. M. Collier: Clinique. (Surgical.) 5.15 p.m. Mr. J. Pardoe: The Treatment of Chronic Urethritis.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W).—5 p.m. Dr. Beddard: Practical Medicine.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (North-Eastern Fever Hospital, St. Ann's Road, N.).—2.30 p.m. Dr. F. M. Turner: Demonstration on Fevers.

THURSDAY, NOVEMBER 9th.

HARVEIAN SOCIETY OF LONDON (St. Mary's Hospital). 8.15 p.m. Cases shown. 8.45 p.m. Discussion.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret St., W.).—8 p.m. Dr. M. Friedeberger: Speech Training of Feeble-minded Children. (Arranged by the Childhood Society.)

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. H. Macnaughton Jones and Prof. J. W. Taylor. Paper:—Dr. S. Savage: Hæmatoma of the Ovary and its Pathological Connexion with the Ripening and Retrogression of the Graafian Follicle.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, W.).—8 p.m. Card Specimens will be shown by Mr. A. H. Thompson and Dr. E. C. Taylor and Mr. E. J. Smyth. 8.30 p.m. Papers:—Dr. J. B. Nias and Mr L. Paton: The Value of the Opsonic Index for Tubercle in Phlyctenular Conjunctivitis (preliminery note). Mr. C. Worth: Hereditary Influence in Myopia.—Mr. Nettleship: (1) Notes on some Varieties of Albinism: (2) Colour Blindness in Women.—Dr. A. J. Ballantyne: A Case of Metastatic Sarcoma of the Optic Nerve Head and Retina.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC, (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. L. Williams: The Therapeutics of Some Common Ailments

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. Davis: Heart Disease—Cardiac Murmurs—Diagnosis and Treatment.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Tuberculosis of the Skin—I., Lupus Vulgaris: II., Tuberculosis Verrucosa Cutis; III., Scrofuloderma. (Chesterfield Lecture.)

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. T. N. Kelynack: Demonstration of Pulmonary Cases. (Post-Graduate Course.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4 p.m. Lecture:—Mr. J. Cantlie: Marlaria, its Parasites and Treatment.

FRIDAY, NOVEMBER 10th.

INCORPORATED SOCIETY OF MEDICAL OFFICERS OF HEALTH (1 Upper Montague Street, Russell Square, W.C.).—8 p.m. Paper: Dr. C. Childs: A Comparative Study of the Lincoln, Maidstone, and Worthing Epidemics of Typhoid Fever. Followed by a discussion.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.)—8.30 p.m. Papers:—Dr. F. H. Hawkins: Case of Suppurative Pylephlebitis connected with a Suppurating Mesenteric Gland—Dr. C. W. Chapman: After-history and Post-mortem Record of a Case of Obstruction of the Inferior Vena Cava.—Mr. G. Simpson: A Successful Case of Splenectomy for Rupture of the Spleen.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. A. Lawson: Clinique. (Eye.)

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road W.).—5 p.m. Mr. Baldwin: Practical Surgery.

Vacancies.

Barra Parish Council.—Medical Officer. Salary £119 per annum. Applications to Thomas Wilson, Solicitor, Lochmaddy, Clerk.

Nottingham General Hospital.—House Surgeon. Salary £100 a year, with board, lodging, and washing. Applications to E. M. Keely, Secretary.

National Dental Hospital, Great Portland Street, W.—Medical Superintendent. Salary £120 per annum. Applications to M. P. Collings Secretary.

Bethnal Green Infirmary.—Assistant Medical Officer. Salary £100 per annum, with furnished apartments, board, and washing being provided. Applications to the Medical Superintendent of the Infirmary, Cambridge Road, N.E.

Brentford Union.—Assistant Medical Superintendent.—Salary £120 per annum, with furnished apartments in the Infirmary, rations, washing, etc. Applications to William Stephens, Clerk to the Guardians, Union Offices, Isleworth, W.

Appointments.

BARNES, ALFRED J., L.A.H., M.P.S.I., Examiner in Preliminary Education, Pharmaceutical Society of Ireland.

BLACK, G., M.B., B.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Hailsham District of the County of Sussux.

BIGGS, GEORGE, M.B., B.S., L.S.A., Clinical Assistant to the Chelsea Hospital for Women.

HOUSTON, J. W., House Physician to the Richmond, Whitworth and Hardwicke Hospitals, Dublin.

O'BRIEN, C. M., M.D., of Dublin, has been elected a corresponding member of the Sociètè Française de Dermatologie.

RUTHERFORD, H. R. C., House Surgeon to the Richmond, Whitworth and Hardewicke Hospitals, Dublin.

Births.

BIDWELL.—On Nov. 6th, at 15 Upper Wimpole Street, London, the wife of Leonard A. Bidwell, F.R.C.S., of a son.

Marriages.

KELLEHER—CAPSEY.—On Nov. 4th, at St. Mary's Church, Holyhead, Thomas Aloysius Kelleher, M.B., of Waterford to Ada Alice, eldest daughter of G. J. Capsey, of Fannow Hill Villa, Castlewood Park, Rathmines, Dublin.

Deaths.

M'AULIFFE.—On Oct. 26th, at his residence, Knock, Co. Clare, Dr Francis M'Auliffe, aged 30 years; deeply mourned by his sorrowing mother, brothers and sisters.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, NOVEMBER 15. 1905. No. 20.

Original Communications.

LECTURE
ON THE
DIAGNOSIS OF FUNCTIONAL NERVOUS DISEASE.

DELIVERED AT THE NORTH-EAST LONDON POST-GRADUATE COLLEGE, ON TUESDAY, OCT. 31ST, 1905.

By ARTHUR WHITING, M.D., M.R.C.P.LOND.

Assistant Physician to the Tottenham Hospital, N., and the Mount Vernon Hospital for Consumption and Diseases of the Chest, and Dean of the College.

THE term functional as applied to disease is probably hardly defensible except on the ground of expediency. It is used, as you know, in contrast with the term organic, and is applied to those morbid conditions in which hitherto no definite structural changes have been found. Within the range of functional nervous disease such maladies as epilepsy, and possibly chorea, would be included, but it is to a narrower group of cases that I wish to direct your attention this afternoon, to those, in fact, which on the Continent are usually spoken of as hysterical, and of these I particularly wish to consider with you the so-called hysterical or functional paralyses, with special reference to their diagnosis.

IMPORTANCE OF THE DIAGNOSIS.

Clinically the cases of functional or hysterical paralysis often more or less closely simulate cases of organic paralysis; like them they often produce a profound disability, but, unlike them, they are as a rule curable. Recovery from such diseases, however, largely depends on their subjects receiving suitable treatment, and hence the importance of their accurate diagnosis. In illustration of this point I will mention a case which I saw some years ago, one that I have more than once referred to already in your hearing. It was that of a middle-aged woman who was admitted into the National Hospital for the Paralysed and Epileptic under the care of my friend and former chief, Dr. Ferrier, suffering from paraplegia. When little more than a girl she was seized with paralysis of her lower limbs which was considered to be organic, probably, I imagine, due to a myelitis, and she was treated accordingly. But as years went on she did not make even the moderate improvement that such cases frequently show. After two or three years the inconvenience of her condition was so great that she was kept permanently in bed, and when at length she was admitted to the hospital she had last walked some twenty-three or twenty-four years before, and she had been in bed for twenty years. On examination it appeared that an error in diagnosis had been made this long time ago, and the event was that after six weeks of hospital treatment she was able to walk about the ward without assistance; it had been all along, in fact, an instance of functional paraplegia.

THE NATURE OF FUNCTIONAL DISEASE.

Little if anything is as yet definitely known as to the essential nature of functional nervous disease, but the following points seem clear. It occurs in persons of what is known as a neurotic constitution, and it follows as a rule a psychical or physical shock. Overwork, worry, and anxiety, especially when in combination, seem to be the chief predisposing causes apart from constitution. It is hardly necessary to say that hysterical conditions have nothing to do with the uterus as the name suggests.

Although it seems certain that the primary stress falls on the higher cerebral centres and that the lower centres are only secondarily implicated, yet the idea of the pathology of functional disease is indefinite and abstract to the last degree. The following considerations, however, may help to give an element of the concrete to our idea of the condition. In regard to the influence of overwork, I would remind you that definite and characteristic changes have been demonstrated in the nerve cells of honey bees on coming back to the hive in the evening after a long foraging expedition, and that similar changes affecting both the protoplasm and the nuclei of the cells have been found in the cerebrospinal axis of dogs after over-exertion. In regard to the influence of outside causes on nerve cells, I would remind you that a paralysis of the limbs, resembling a functional paralysis, has been produced in monkeys by dividing the posterior or sensory roots corresponding with the respective limbs, and that intracellular changes to some extent comparable with those induced by fatigue have been found in the anterior horn cells of the cords of these animals after such section.

These facts suggest what might be assumed on other grounds that the underlying change in the nervous system is a nutritional one, affecting probably the nerve cells. But there is another influence—a positive one—for the existence of which there is ample evidence which may be considered in building up a working hypothesis. This is the idea of the inhibitory or restraining action of higher centres on the lower, abolishing, if powerful enough, for the time being, the expression of their function. In illustration of this point I would merely remind you of the barrister with an early brief who, standing up to address the Court, is unable to utter a word, and the actor who is the unfortunate subject of so-called stage-fright. That, I fear, is all I can offer in the direction of suggested explanation of the pathology of functional disease. The difficulty of even searching for a recognisable histology in the human subject is obvious, inasmuch as patients do not die from that disease.

THE QUESTION OF DIAGNOSIS.

The diagnosis of functional nervous disease consists to a large extent in the exclusion of organic disease. There are, however, two side-issues that must be kept in mind: one is that functional and organic affections may occur together in the same patient and at the same time; and the other is the possibility of malingering. The combined cases I shall consider later, but in regard to the question of malingering, I would here say that in my own experience, at any rate, it is rare, and I would repeat that functional disease is real disease.

Individual Signs of Organic Disease.

To clear the ground somewhat, let me mention certain symptoms and signs which, if not absolutely conclusive evidence of organic disease, are, at any rate, so nearly that as to be practically unequivocal. Among others are the following:—(1) Absent knee-jerks; although it must be said that with infinite rarity they may be congenitally absent, and that fairly commonly they may be found absent for years after recovery from diphtheria.

(2) Ankle clonus of the true variety; there is a spurious clonus which I shall describe.

(3) The extensor plantar reflex, or Babinski's phenomenon, which I shall demonstrate to you at the end of the lecture.

(4) Iridoplegia, or the Argyll-Robertson pupil, which, however, must be looked upon rather as evidence of previous syphilis than of tabes or general paralysis.

(5) Optic neuritis, which may, however, be simulated in hypermetropia, or occur in anæmia, uræmia, &c.

(6) Optic atrophy, which must not, however, be diagnosed on account of the pallor of the discs alone (that might be due to anæmia), but must be conjoined with diminished visual acuity, after all errors of refraction have been corrected to have this special value.

(7) Hemianopsia, or blindness of one-half of each retina.

(8) Nystagmus, of the sustained true variety. A nystagmus, however, may be seen in miners, in albinos, and in some healthy persons from local eye changes.

(9) A localised paralysis or atrophy. It may be of an ocular muscle giving diplopia, or of certain "picked out" muscles in the limbs.

(10) Reaction of degeneration, partial or complete, particularly the slow worm-like contraction to galvanism.

(11) Anæsthesia, limited in its distribution to the anatomical supply of a segment, root, portion of a plexus, or nerve.

(12) Girdle sensation.

(13) Bed sores, and

(14) Persistent incontinence of urine, especially if associated with cystitis.

Signs Suggestive of Functional Disease.

The following signs, on the other hand, without perhaps meriting the term unequivocal, are yet highly suggestive of functional disease:—

(1) A hemianæsthesia, especially of the left side, limited by the middle line, including the mucous membranes and including the special senses on the same side.

(2) A concentric contraction of the visual fields, more marked on the anæsthetic side of the type of what is known as a crossed amblyopia, with inversion of the colour fields.

(3) An inconsistent partial anæsthesia, *i.e.*, one not limited to any anatomical distribution of nerves, as when occurring in islets.

(4) An inconsistent muscular paralysis.

(5) Anæsthesia of the hand, and yet the power to use the fingers for fine work, as in sewing, &c.

(6) An absent plantar reflex, and a very sluggish pharyngeal reflex.

(7) Demonstrative knee-jerks, by which I mean that the whole body undergoes commotion, and the patient complains of the jerk causing discomfort in the muscles of the thigh and abdominal wall.

(8) Blepharospasm, or nictitation of the eyelids.

Types of Functional Disease.

The functional disease *par excellence*, in the general opinion of the profession, is the functional or hysterical fit; but beyond saying that I consider there is good evidence to show that such seizures are sometimes really of the nature of post-epileptic automatic states, and that in most, if not all, cases they are emphatically not shammed, I must leave that part of the subject untouched.

The principal types of functional disease may for our purpose be grouped into plain cases and subtle cases. Of the plain cases functional hemiplegia, monoplegia, and paraplegia are well recognised, and I propose to discuss them at some length, but functional laryngeal paralysis, functional dysphagia, functional contractures, hyperæsthesia, joint affections, and the psychical manifestations of hysteria might all receive with advantage detailed consideration.

Of the subtle cases I will take, as an instance, those in which functional and organic signs are combined in the same patient. And, lastly, I will describe the simulation of functional disease in definitely organic cases, taking as an instance early cases of disseminated sclerosis which are probably most frequently confused with functional disease.

Functional Hemiplegia.

Hemiplegia of functional origin is seen chiefly in young women. The only cause of organic hemiplegia which is at all common in them is cerebral embolism from mitral stenosis. In young men an organic hemiplegia is more frequently due to cerebral thrombosis from syphilitic endarteritis; in people beyond middle life the ordinary causes are thrombosis and cerebral hæmorrhage, and in children it is a cerebritis or cortical thrombosis from infectious diseases.

Functional hemiplegia nearly always attacks the left side, perhaps four times as often as the right. Why this should be I have no valid explanation to offer.

The onset of the paralysis is usually gradual, and it not infrequently develops a few days after some emotional shock. The shock is, of course, only one factor in its incidence, the other is an inherited weakness of the higher nerve centres. A physical blow, as from a moving object striking a light person, might knock him down, while from a more substantial person the object might merely rebound.

The paralysis in a functional hemiplegia in nine cases out of ten is not a hemiplegia at all, inasmuch as it does not affect the face. The stress of the malady falls on the left arm and leg. The limbs may be flaccid or rigid. In organic hemiplegia, after the first few days the paralysed muscles become progressively rigid, the stronger muscles overcoming the weaker. In functional paralysis, if there is rigidity there is no manifestation by posture of the normal preponderance of strength of one group over another. To take the upper limb, for example, in organic cases the elbow is flexed, the forearm is pronated, the wrist is flexed, and the fingers are bent at the metacarpo-phalangeal joints. In functional cases the elbow is often extended, the forearm supinated, the wrist extended, and the fingers hooked into the palm. To take the lower limb, in organic cases the heel is drawn up and the foot inverted, and in walking the whole limb is circumducted, the great toe region of the foot being scraped on the ground. In functional cases the limb is probably kept rigidly straight, and in walking the foot is usually either dragged after the patient as if it were the head of a mop, the dorsum of the foot scraping the ground, or it is pushed in front of the patient as if progressing on one skate. In no case is there the circumduction of the limb so characteristic of the organic disease.

In organic hemiplegia the sensibility of the limb may, of course, be intact, depending on the position of the brain lesion, but in functional cases there is usually hemianæsthesia in addition to the paralysis. The functional hemianæsthesia differs from the organic in the following points: It is as a rule (1) much more profound, (2) it extends with equal intensity right up to the middle line, but does not go beyond it, and (3) it involves the mucous membranes; and (4) it is usually associated with implication of the special senses on the same side. In organic hemianæsthesia the loss of sensibility is usually more profound at the extremities and gets appreciably slighter towards their distal attachments, and on the trunk it extends beyond the middle line, and it does not involve the mucous membranes. In the functional cases, too, the sensory loss is more analgesic than tactile, and sometimes the analgesia is complete, involving both sides, as shown in one of the photographs I shall throw on the screen.

The character of the reflexes even in the cases of functional hemiplegia with rigidity will unmistakably differentiate it from the organic type. The knee-jerk is exaggerated as a rule, it is true, but not more so on the paralysed side, as in the organic cases, than the sound side. There is no definite evidence of lateral sclerosis as found in the true ankle clonus, and the extensor plantar reflex so distinctive of the organic cases. There may be a false ankle clonus, and by that I mean a vibration with the toe in the pointed position, an irregular clonus the first movement of which is a plantar flexion and one that diminishes as the foot is bent firmly into the dorsiflexed position. The true clonus occurs only in the dorsiflexed position; it is regular, the first movement is of dorsiflexion, and often the more the foot is pressed up the more marked does it become. In the functional cases no plantar reflex may be elicited, or it may be obtained with difficulty; but when present it is always flexor.

A sign which possibly depends on the presence of lateral scleroses in the organic cases is described by Babinski under the title of "Combined Flexion of the Thigh and Trunk." The patient is directed to cross his arms over his chest and make the effort to raise himself from the recumbent to the sitting posture, then on the sound side the lower limb remains motionless, but on the organically paralysed side the thigh becomes flexed on the trunk and the foot is raised from the bed. In functional hemiplegia both lower limbs remain stationary.

The special senses are usually in some degree affected on the same side as the hemianæsthesia in functional cases, while in organic cases this is rare. Smell may be diminished or lost in functional cases on the same or on both sides. Taste also may be lost on the anæsthetic side, although the patient may not be conscious of it until it is revealed by testing. Hearing, too, may be diminished or lost on the same side, and be more acute on the opposite side. The alteration in sight is more crucial; in the organic cases it is generally hemianopic, the right or left halves of the retina being blind; in functional cases there is concentric contraction of the visual fields, and that frequently to an extreme degree, but the field on the anæsthetic side is the more contracted. It is of the type known as crossed amblyopia and is usually accompanied with inversion of the colour fields, red being seen before blue. A characteristic feature in the functional cases is that the field gradually becomes smaller as it is being transferred to the perimeter chart, so that the tracing assumes an internal spiral or helicoid shape.

FUNCTIONAL MONOPLEGIA.

Functional monoplegia has to be differentiated from an organic cortical monoplegia, which is in itself somewhat rare. It occurs more commonly, according to my own experience at any rate, in men than the hemiplegia. It more usually affects the arm than the leg. The affected arm does not drop limp in the early cases as in organic paralysis; the opposing muscles may be felt, too, to contract when an attempt at movement is made. In the later cases there may be no contracture, or if any, it is of a different type from the organic contracture, the thumb being bent into the palm. The sensory difference is marked; in the organic cortical cases there is, according to my own observation and belief, and following one school of neurologists, a slight blunting of tactile sensibility, accompanied by defective localisation of touches more marked on the hand and wrist, usually, but varying in degree and position with the degree and position of the paralysis. In the functional cases the anæsthesia and analgesia are profound, their distribution is more extensive, as a rule, than the paralysis, as in the photograph of a patient I shall show you, and it is often in the form of islets which is itself, I think, pathognomonic and most often of all its upper limit is bounded by a geometrical outline as of a glove, stocking, or sock, and it has sometimes, therefore, been called an amputation anæsthesia. In regard to the lower limb the reflexes are like those of the limb in functional hemiplegia.

FUNCTIONAL PARAPLEGIA.

Functional paraplegia may occur in women or men, but according to my own experience it is more common in children about the age of puberty, or a little before. Unlike functional hemiplegia it usually occurs almost immediately after a shock of some sort. It may be flaccid or spastic, but contractures commonly develop in the long-standing cases, giving much rigidity. In these there may be muscular atrophy, but there is never any reaction of degeneration to the electrical currents. The gait is nondescript, but it is never like the spastic gait with toe scraping of organic paraplegia. Sensation is commonly lost over the lower limbs, but not with the segmental outlines of the organic case, as in the diagrams I show you. The upper border is usually transverse to the long axis of the limb as of a stocking or sock. Perhaps the site most likely to be confused with the organic cases is when the upper level of the anæsthesia is about the knee, because the organic sequential anæsthesia is fairly transverse at this level, but in the organic cases a tongue of preserved sensibility passes down over the middle of the upper part of the back of the calf, and in the functional cases it is transverse all round. The reflexes show the characters described under functional hemiplegia, viz., excess of knee-jerks, no true ankle clonus, and an absent or flexor plantar response. There is no paralysis of the sphincters as is so commonly seen in organic cases.

COMBINED FUNCTIONAL AND ORGANIC CASES.

The combination may be many and various. Perhaps the most commonly seen are in cases of cerebral tumours, where much "rousing treatment" has been energetically employed in not a few instances before the organic nature of the case has been recognised. Reference to a case that has come under my own observation will explain the sort of diagnostic pitfall that has to be looked for. A young woman of emotional temperament had all the signs of a functional hemiplegia, and such, while under constant observation, it was for several weeks considered to be; then one day it was noticed that the muscular substance of the front of the leg below the knee seemed of small bulk, the electrical reaction of the muscles of the limb were taken, and it was found that the anterior tibial muscle, and that apparently alone, gave the reaction of degeneration. The case was one of anterior poliomyelitis with a superadded functional hemiplegia.

ORGANIC SIMULATING FUNCTIONAL DISEASE.

So far I have refrained from mentioning the names of any authorities in support of the observations I have made, but I feel it only fair to say that it is to Dr. Thomas Buzzard, above all others, that medical men at home and abroad are indebted for pointing out the resemblance between early cases of disseminated sclerosis and functional disease. There can be no doubt, I think, that the greatest number of mistakes in failing to recognise the organic nature of certain apparently functional symptoms has been in the instance of early disseminated sclerosis. The history of such a case is something like this. A young woman, perhaps after some intellectual or emotional stress, complains of transitory loss of power, it may be, in one arm. After recovery this again becomes paretic, again to recover, but at length it does not recover but remains weak. Similarly a transient diplopia is complained of, then, it may be, various parӕsthesiӕ in the limbs and at length vesical or rectal incontinence. But before the onset of the latter almost unequivocal sign of organic disease defective sight may have become obtrusive, and an ophthalmoscopic examination may have revealed a degree of primary optic atrophy. The case is one of early disseminated sclerosis. In the functional cases there may be contraction of the visual field, but the discs are healthy. Diplopia in functional, excluding toxic cases, is almost unheard of. There is in the more advanced cases of disseminated sclerosis a regular nystagmus, but this is not seen in functional cases, although the eye may jerk somewhat on extreme lateral deviation, probably from muscular asthenia. The staccato, slurring, syllabic articulation of disseminated sclerosis is not met with in functional cases, though there is often a clumsy articulation, but, on the other hand, the characteristic speech does not occur in all cases of disseminated sclerosis. In functional cases the paralysis may be flaccid; in developed cases of disseminated sclerosis it is spastic, but in the early transient palsies the limb is flaccid. The intention tremor of disseminated sclerosis—the tremor which increases up to the apprehension of an object, or, *e.g.*, as the nose is approached with the finger—is not seen in functional disease, although there is a fine rhythmical tremor often seen. Loss of sensibility is usually early and profound in functional cases, while it is slight or, if marked, only so in the late cases. The reflexes are characteristic of lateral sclerosis in disseminated sclerosis—excessive knee-jerks, true ankle clonus, and extensor plantar response—while in functional disease there is no true ankle clonus and the plantar response is flexor or absent. In disseminated sclerosis there is often incontinence of urine, but never in functional disease, although there may be retention. Girdle sensation is frequent in the organic, but not present in the functional disease.

CONCLUDING REMARKS.

I should particularly have liked to have said something about traumatic neurasthenia, but this must be reserved for a future opportunity. I would, in conclusion, emphasise again (1) the importance of the diagnosis of functional disease from the point of view of prognosis, for the failure to diagnose it may mean the loss of a large part of the useful life of truly suffering and really honest persons; (2) that the method of diagnosis is largely one of exclusion, and to make the diagnosis with confidence, and hence to obtain the full therapeutic effect of a reassuring opinion, a careful examination of the patient should be made from top to toe; (3) that functional and organic disease may exist in combination; (4) that it is better to miss diagnosing functional disease than to diagnose it when a serious disease is present; and (5) that in all cases of apparent functional nervous disease, especially when occurring in young women, the possibility of its indicating early disseminated sclerosis should be kept in mind.

THE INCREASE OF INSANITY IN IRELAND AND ITS CAUSES. (a)

By M. J. NOLAN,

Resident Medical Superintendent, Down District Asylum, Downpatrick.

III.—ETIOLOGICAL.

> "The knowledge of a very large number of facts such as occur in the natural course of events, the knowledge acquired not by accounts of various reading, but by personal observation, first-hand after a ripe age, and experience in public affairs, constitutes the safest means of investigation in every study of human society, and in most historical studies."—M. D'HARCOURT.

> "This is the tenor of my belief, wherein though there be many things singular and to the humour of my irregular self, yet, if they square not with maturer judgments, I disclaim them, and do no further favour them than the learned and best judgments shall authorise them."—*Religio Medici.*

To say that insanity is due to stress is a statement which advances very little our knowledge of *why* it influences mental operations, and causes reason and conduct to part company; we must, however, be satisfied that such is its effect on the mind. The weak bone of a ricketty child snaps, and the biceps of a Sandow tears under undue strain, so likewise the cohesive elements which keep reason, will and emotion in normal and harmonious accord, are ruptured when subjected to too severe a degree, whether the stress is inherent in the individual constitution or comes from an assault made from outside.

The conditions, therefore, which occasion stress or strain in the gross mental constitution of a nation are the conditions which produce insanity in its weaklings, and they must necessarily embrace the causes of insanity. Stress, then, and insanity stand in twin relation to the whole human family, and inasmuch as insanity is one, and perchance the worst of the thousand hereditary ills, stress of a general character which produces it is a necessary incidental to all the ordinary conditions of every-day life. In the ordered distribution of things, stress plays a very unequal part, since we have nations of "lotus eaters," and nations who are but in the main "hewers of woods and drawers of water." So that while there is a general stress, the circumstances in some cases are so very exceptional that we may say there is also a Special Stress, a zymotic or preventible stress, as it were. Ireland gets her full share of the general stress, and rather more than her full measure of the special stress.

The annexed table will perhaps be the best means of showing at a glance the general operations of stress on the community. As it would be impossible to discuss within our limit even the leading *rôles* it plays, in so many and such strange situations, some brief observations are hazarded to help to elucidate its bearings. It is framed to some extent on arbitrary lines, yet in many instances the conditions noted are interdependent. Some apology perhaps is also due to the departure from departmental nomenclature. But it must be remembered that for obvious reasons one cannot expect to find the increase of insanity as recorded in Departmental Blue Books ascribed to the fundamental causes. These may be, and no doubt are, clear enough to the compiler, but they are of too controversial a character to permit of cautious and delicate handling, on the part of those whose duty it is to record effects rather than to probe underlying causes. Yet if we ever hope to touch the real and active seat of the disease we must disregard conventional forms and boldly lay bare the roots of the evil, however unsightly they may be. The question is one that cannot be confined to officials and specialists. The causes of insanity are bound up in the history and present daily life of the people—the process of mental degeneration grows there like canker, and dreadful as it is, the hope of better things lies also therein, since it is possible for each and every one of the community to assist to a large extent in the removal of the evils which impede a true regeneration.

To illustrate the operation of general stress the etiological groups of the Table V framed and adopted by the Medico-Psychological Association of Great Britain and Ireland have been used. The headings explain themselves, and need no special comment, with perhaps a few exceptions which may be noted from an Irish point of view.

Group A.—Operates within its normal limits.

Group B.—1. Prolonged anxiety and worry exists owing to a combination of circumstances to an undue degree, compared with other countries. 2, 3, and 4 exercise no special influence.

Group C.—I. and II. HEREDITY.—It is obvious that this factor must largely influence occurring insanity, since so many are insane, and each one has a family connection. Heredity in its psychological aspect if it means anything means that there is in some families a predisposition to break down mentally under undue strain. This predisposition, fortunately, may be neutralised by environment; unfortunately, in Ireland it is more often strengthened by adverse surroundings, such as a close combination with alcoholism (5) or tuberculosis (6) or, as sometimes seen, with both. 3 and 4 are but of ordinary account.

Group D.—1, 2, and 3.—It is not unlikely that where heredity is so much in evidence the epoch of age, as periods which normally test physical and mental capacity, exercise rather more the usual stress and elicit more failures.

Group E.—1, 2, and 3.—To these as periods of stress the same observation applies.

(a) Being the third of a series of articles dealing with lunacy matters, specially contributed to the MEDICAL PRESS AND CIRCULAR.

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Group F.—1.—Privation (and starvation) is undoubtedly a very fertile cause, and closely intimate with Group I. in all its sub-groups. ; 2.—Over-exertion (physical) is comparatively rare at home; 3 and 4 operate less than elsewhere.

Group G.—1.—Alcoholic is so important that it must also be considered as a special stress ; 2 and 3 have very much less than the usual part to play ; the same may be said of 5, 6 and 8 ; 4.—Tuberculosis is a great primary cause and by so frequently following influenza, (7) the latter also is a not infrequent element in exciting mental disturbance.

Group H.—1—Very little influence ; 2.—Operations, only as resulting from the conditions under Group J. 3.—Sunstroke does not play any direct *rôle.* Those who are stated to have suffered from it were at the time out of the country and exposed to mental and physical stress of many kinds, emigration, or excesses, or ill-health.

Group I.—1 and 2 of no special importance ; 3 rather less than in other countries. 4.—Neurotic diathesis, so closely allied to Group C. (1) (direct insane heredity) that the line of demarcation cannot be readily drawn. 5.—No evident undue factor.

Group J.—*Mens sana in corpore sano* applies here —unquestionably much insanity is due to the stress of bodily disease.

Group K.—Congenital and infantile mental defect covers a large proportion of the insane who develop acute forms of insanity when subjected to any stress. With particular reference to Ireland, the alcoholic habits of parents (more particularly mothers) results in procreation of offspring who exhibit varying degrees of deficiency from a mere weakness of intellectual faculties and of moral sense to the most pronounced idiocy.

It may be said that it is unnecessary to seek further causes than those which the foregoing elaborate table covers. The subject, however, is not confined to the *causes*, but also embraces some slight notice of the *conditions* which tend to give such startling prominence to lunacy in the Census Returns. Hence it is necessary to glance at the special stress which is divided into eight major groups—Climatic, Agrarian, Emigration, Religious, Educational, and Psychological.

Group L.—Climatic.—The humidity of the climate has always been held responsible for much of the depression and general inertness which is so evident in the Celt, and is also made use of as an extenuating circumstance to minimise his guilty abuse of alcohol. However far-fetched the latter deduction may be, there can be no question of its influence on tuberculosis and rheumatism, two conditions of ill-health which are very common and not infrequently accompanied by mental disease. In a country, then, where there are so many poor persons broken down in general health, the climatic conditions cannot be ignored. And again it comes into play as "protracted anxiety," which is incidental to all agricultural communities, but which is particularly acute in Ireland. Though we are free from wild fulminations of more extreme climates, we still experience ranges of severity which render farming results at all times hazardous and sometimes disastrous, entailing absolute ruin on those who for their existence depend solely on the produce of the land. This explains the special importance of climatic stress to Ireland, since like conditions would not so injuriously strain other countries less purely agricultural.

Group M.—Agrarian.—Under this head stress has played the leading part all through Ireland's history—the "Fight for the Soil" comes first and last and runs all through the pages. Invading colonies contended for it ; Kings, Chief and Petty, strove for supremacy ; clans raided each other ; settlers and planters wiped out the native "mere Irish," driving the latter into more remote and less prolific districts, where they in turn contended for possession. There were continual "settlements," "clearances," and "distributions," all combining to the uncertainty of tenure and the neglect of the culture of the land ; hence to a constant drag of stress on the mind and a source of increasing poverty.

In more recent times the long chain of "Land Acts," each the result and precursor of fresh agitation, with its rack-renters and evicted ; its emergency men and boycotters—"the unconcentrated energy" of the people absorbed in land politics ; the land itself meanwhile receiving only scant attention from the people who, in the fight for its ultimate possession, lost interest in its immediate cultivation. Perhaps it is not an exaggeration to say that nowhere has the "bone and sinew" of the people been subjected to such "protracted stress" which must have a very detrimental effect, and which constitutes, where the constitution is normally emotional, a predisposing element to mental instability.

In consequence of this uncertainty of tenure the best has not been taken at all times out of the soil. This has engendered carelessness in farming and a growing dislike to field labour, with bad results. It has also been fostered by the improved mechanical appliances or "labour-saving" machines and artificial manures.

In other countries there are several specific ailments associated with diseases of the nervous system, and which are grouped as "occupation neuroses." In the same sense these conditions are not appreciable in Ireland. Since agriculture is, however, the mainstay here, and land labour is at once the most onerous, anxious, and exposed class of work it may be said to constitute the occupation of the labourers. Their break-down from it may be justly described as a neurosis when it takes the form so common and familiar to medical men and asylum physicians in country districts of that of neurasthenia resulting from too prolonged strain, combined with anæmia due to partial privation.

Group N.—1. Voluntary Emigration embraces all those ambitious professional men, small capitalists, and skilled artizans. They constitute a numerous class, which is growing yearly. It also includes those who enter the military, naval and civil services —a goodly band—who, though obliged to go by the terms of their service, are voluntary in the sense of having made a deliberate choice. Many doing well at home also go.

"Alas, alas, that it should be so ; that the children of our own dear land should fly from the soil where they sprang ; that the *mal de pays* of the Swiss mountaineers should be reversed in Irish bosoms, driving them, with a passionate ardour which is the sacred due of fatherland alone, to seek the inhospitable wilds of a newer world. Yet why marvel at that feeling nowadays ? The evil was done in the age that is past ; the broad way across the Atlantic was paved in the last generation ; and now they who hurry away, fly not to an unknown land, but to one that draws their hearts by a thousand bonds. They go to meet friends and kindred, and homesteads, to where brothers and sisters, or children await them. And, where they all are, that is their country."* How much has this statement gained in force by a lapse of nearly sixty years ?

2.—Obligatory or necessitous emigration comprises the bulk of emigrants, who must go, or starve at home. To a large extent it represents the most energetic, and consequently leaves a more apathetic class behind.

3.—"Back-stream" emigration may be said to return to us again the physical and mental failures, the undesirables, the ne'er-do-wells, *et hoc genus omne.* They are weeded out, some on their arrival at their destination, others after years spent in other countries, but sooner or later they are returned to swell the social wreckage.

Group O.—Religion.—1.—The ethics of the majority are of a high moral order, and as there is a long step between the physiologically adult and the economically adult age, there is much suppression of one of the strongest human emotions. In this struggle many

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* *Dublin University Magazine*; 1846.

Table indicating the General (1) *and Special* (2) *Associated Conditions* (3) *which tend to increase the number of the registered Insane in Ireland.*

I.—STRESS.

GENERAL STRESS (4).

MENTAL STRESS.

Group A.—Sudden.

1.—Nervous shock and intense emotion.

Group B.—Prolonged.

1.—Anxiety and worry (not sudden).
2.—Disappointed affection.
3.—Mental overwork.
4.—Solitude.

PHYSICAL STRESS.

Group C.—Heredity.

1.—Insane—direct.
2.—Insane—collateral.
3.—Neurotic—direct (epilepsy, hysteria, spasmodic asthma, and chorea).
4.—Of paralysis—direct.
5.—Alcoholic—direct.
6.—Tuberculous—direct.

Group D.—Critical Periods.

1.—Puberty and adolescence.
2.—Climateric.
3.—Senility.

Group E.—Childbearing.

1.—Pregnancy.
2.—Puerperal state.
3.—Lactation.

Group F.—Psychological Defects and Errors.

1.—Privation and starvation.
2.—Over-exertion (physical).
3.—Masturbation.
4.—Sexual excess.

Group G.—Toxic.

1.—Alcohol.
2.—Syphilis—congenital.
3.—Syphilis—acquired.
4.—Tuberculosis.
5.—Drug habit (morphia, cocaine, &c.).
6.—Lead and other such poisons.
7.—Influenza.
8.—Other specific fevers.
9.—

Group H.—Traumatic.

1.—Injuries.
2.—Operations.
3.—Sunstroke.

Group I.—Diseases of the Nervous System.

1.—Lesions of the brain.
2.—Lesions of the spinal cord and nerves.
3.—Epilepsy.
4.—Neurotic diathesis.
5.—Other neuroses (viz., hysteria, chorea, spasmodic asthma, and occupation neuroses).

Group J.—Other Bodily Affections.

1.—Hæmopietic system (anæmia, &c.).
2.—Cardio-vascular system.
3.—Respiratory system (including tuberculosis).
4.—Gastro-intestinal system.
5.—Renal and vesical system.
6.—Generative system.
7.—Other diseases (stating them), *e.g.*,
  (*a*) Diabetes.
  (*b*) Myxœdema.

Group K.—Congenital and Infantile Mental Defect.

SPECIAL STRESS.

Group L.—Climatic.

1.—Affecting general health—Rheumatism, tuberculosis.
2.—Affecting mental state—Depression.
3.—Affecting agricultural prospects—Anxiety for crops.

Group M.—Agrarian.

1.—"Land Question"—Constant strife.
2.—Neglect of soil; bad farming, poverty.
3.—Effects of exposure in farm labour replace "occupation neuroses."

Group N.—Emigration.

1.—Voluntary—Exodus of material for middle class.
2.—Obligatory—Exodus of labouring class.
3.—Back-stream—Return of undesirables.

Group O.—Religion.

1.—The ethics of the majority.
2.—Emotional revivals, missions, etc., of all sorts.

Group P.—Education.—

1.—Primary; past penal starvation; present ill-adapted.
2.—Intermediate; strain of "cram."

Group Q.—Alcoholic.

1.—Primary effect excites acute insanity, particularly in predisposed subjects.
2.—The acute cases, chiefly recoverable, procreate neurotics.
3.—Neurotics procreate persons particularly prone to insanity.
4.—Maternal alcoholism tends to production of idiocy.
5.—Alcoholic excess is oftentimes the *result*, not the *cause* of insanity.

Group R—Century Psychology.

1.—General "spirit of unrest," especially congenital to the Irish mind.
2.—Decline in "family life," facilitated by emigration.
3.—"Conventionalism" more intolerant of individualism in the community; "eccentrics" more frequently certified insane.
4.—The "Problem Play," and prurient novel.

Group S.—Administrative Lunatic Asylums.

1.—Primarily by being the receptacle for all grades of mental wreckage, which is variously dealt with in other countries.
2.—Reduction of death rate in these institutions.
3.—Accumulation of the unrecoverable cases.
4.—Discharged adults procreate mentally unstable offspring.

(1.)—"General" in the sense of universal or common to all countries.
(2.)—"Special," in the sense of limited more particularly to Ireland.
(3.)—"Conditions" which tend to increase of registered lunacy not to be confounded with the causes of insanity.
(4.)—The groups under this head have been taken from the Actiological (Table VI.) recently drawn up and adopted by the Medico-Psychological Association of Great Britain and Ireland.

fall not (as has been alleged by those ignorant and incapable of appreciating the real conditions) into baser courses, but into various mental introspective phases which not infrequently end in disorder of the intellectual faculties. "Scrupulous" persons are much more common in Ireland than sexual psychopaths. In other countries passion finds a ready promiscuous outlet; here it more often perishes in self-abnegation. We have also the fact that the numerous religious orders, male and female, are constantly recruited at home. Hence the contention that all the best equipped mentally and physically leave the country is false, since those who are best morally, intellectually, and physically enter religious life. Their example influences and attracts endless novices, who in leaving the world die a civic death. They are in truth "the flower of the flock," and justify by their unrivalled physical and mental health, the victory of mind over body. And many such go forth also to all parts of the civilised world in obedience to the same call, leaving the country the poorer in every sense.

2.—In a country where contending sectarianism runs high, emotional revivals and missions are frequent on all sides and act as an exciting cause of break-down in highly-strung individuals. This is an ascertained fact. How many are, on the other hand, brought back to moderate courses cannot be so easily estimated.

Group P.—EDUCATION.—1.—Primary education is of comparatively recent introduction and followed on an organised system of mental sterilisation. Competent authorities deem it unsuitable. It is in its present shape a contributory cause to the weaning of the labourer from the soil.

2.—Intermediate education is also in an unsatisfactory state; many intelligent youths have broken down mentally under the "cramming" for "results."

Group Q.—ALCOHOLIC.—This is directly and indirectly a fertile cause of insanity, though perhaps its *rôle* so far as Ireland is concerned has been overestimated, since in the current report of the English Commissioners it gets primary consideration as a cause of insanity in England, and is shown to have an incidence with prosperous labour centres. In any case, as recently accentuated by Dr. Conolly Norman, the Irish people are constitutionally unfitted for alcoholic indulgence. The facts noted under 1, 2, 3, 4, and 5 are well established.

With reference to the latter the English Commissioners noted:—

"It should be borne in mind that such intemperance is frequently as much an effect of brain weakness as a cause, and the intermingling of these renders it impossible to arrive at precise conclusions. In any case, it cannot be denied that alcohol is a brain poison, and it is therefore incumbent to show what part it plays in insanity."

Group R.—CENTURY PSYCHOLOGY.—Every age has its psychological complexion, and the special features of the present time would seem to be:—

1.—A universal "spirit of unrest"; and of high pressure in every phase of society.

2.—To some extent as a result of this spirit there is a marked tendency to break off the cohesion of family life, each member asserting his independence in "striking out" for himself. Not infrequently the "bundle of sticks" had better remain bound up together.

3.—The surrender to conventionality is stamping out individualism, and any divergence from approved stereotyped uniformity of conduct is regarded as intolerable. The Irish mind is antagonistic to much modern conventionalism.

4.—The pernicious effect of dealing with "problems" prurient in type in novels and on the stage, *pour passer le temps* of ignorant persons is very detrimental.

Group S.—ADMINISTRATIVE LUNATIC ASYLUMS.

1.—Elsewhere there are many classes of institutions for the mentally deficient—in Ireland the District Asylum is the chief receptacle for ALL mental wreckage.

2.—The efficiency of these asylums tends to prolong the duration of life.

3.—Hence it is that the accumulation of cases is ever increasing.

4.—The efficiency likewise results in the discharge of very many adults who frequently procreate mentally unstable offspring.

It is at once evident that the groups of the above table are of necessity based on somewhat arbitrary lines, which are really non-existent in actual life. Each group may be said more properly to represent a sphere of influence with zones of varying degrees, which are almost all contingent, and very frequently overlapping. They embrace practically all the conditions of social environment and on that environment must depend the progression or retrogression of the country's mental health.

It would seem indeed a gloomy outlook, so deep sealed and complex are the problems involved. But the world is and has been since the beginning in a state of evolution, and in the hands of the great Architect, it has been an evolution of progress. Ireland is only a portion of the great world; its destiny is safe in His hands. But everyone has his duty, and He who guides all would have us remember that "Wisdom is the principal thing; therefore get wisdom, and with all thy getting get understanding."—(Proverbs, iv., 7.)

A CASE OF

LYMPHOSARCOMA,

WITH REMARKS ON THE RELATION OF THAT PROCESS TO HODGKIN'S DISEASE.

By T. GILLMAN MOORHEAD, M.D., M.R.C.P.I.,
Physician, Royal City of Dublin Hospital.

In spite of the fact that Hodgkin's disease has been recognised as a clinical entity now for nearly eighty years, and that a great deal of pathological research has been expended on the numerous cases that have been recorded, much confusion still exists in the minds of both clinicians and pathologists as to the exact limitations of the group of cases to which the name should be applied. Much of this is undoubtedly due to the large number of names which have been given by writers to apparently identical conditions, and also to the use of the term "pseudo-leukæmia," which implies a by no means proved connection to exist between the disease and true lymphatic leukæmia, but some of it must be ascribed to the great variations in type that are met with, and to the difficulty or even impossibility of distinguishing clinically between the more acute varieties, and the disease known by modern pathologists as lymphosarcoma. The general trend of microscopical investigation has been in this, as in other diseases, to separate and divide, so that instead of recognising one single morbid process corresponding to the Adénie of Trousseau, one is constrained to divide lymphadenoma into acute and chronic, superficial and deep, varieties, and to recognise also lymphosarcoma, leukosarcomatosis, and possibly true sarcoma of the lymphatic apparatus. Clinical observation has not, however, kept pace with laboratory work, and it is in consequence of importance to place on record full accounts of anomalous cases, in the hope that thereby more light may be thrown upon the natural history of these resembling diseases, and our prognosis and treatment amended.

The following case appeared for months to be a typical example of chronic Hodgkin's disease, but the acute termination, and the subsequent examination led to a change in the diagnosis. Whether, however, this was justified or not will be discussed later.

R. H., æt. 50, by occupation a sempstress, unmarried, was admitted to the Royal City of Dublin Hospital, on May 7th, 1905, complaining of general weakness and of slight breathlessness upon exertion.

She stated that she had been perfectly well till the previous December, when she first began to feel weak and tired after exertion. She did not recollect having had any other illnesses, but said that about two years before admission some lumps had formed in her groin, and that one of them had broken down and discharged for about a month. About the same time lumps had also appeared in both sides of her neck and under the arm, and had slowly enlarged. No history of syphilis or tuberculosis could be obtained.

On admission she was found to be a flabby, sallow-looking woman, and distinctly neurotic. On each side of her neck in front of the sterno-mastoid, but most marked on the left side, there were enlarged lymphatic glands, varying in size from a bean to that of a walnut. They were quite distinct from one another, were hard and firm, and were not tender on pressure. Similar enlarged glands were present in both axillæ and groins, while in the left groin there was a scar corresponding to the old abscess above referred to. There was no sign of venous obstruction in the head and neck or elsewhere. The lungs presented a few scattered ronchi over the bases, but were otherwise normal, and there was no dulness on percussion over the manubrium sterni. Heart normal, pulse 72 to the minute, abdominal organs normal, spleen not palpable, urine normal. The temperature during the patient's stay in hospital fluctuated slightly above and below the normal level.

A blood examination, repeated on several occasions, showed that the hæmoglobin was reduced to 60 per cent. and the red cells to 4,000,000 per c.m.; there was no poikilocytosis. The white cells were much reduced, varying on different days from 3,000 to 4,000, but never exceeding the latter figure. A differential count gave the following results:—

Neutrophile cells,	68 per cent.
Eosinophiles,	6 per cent.
Lymphocytes,	17 per cent.
Hyaline cells,	9 per cent.

A diagnosis of chronic lymphadenoma was made and the patient was placed on an arsenical mixture with full diet, but after remaining in hospital for about a fortnight she returned to her work, feeling somewhat stronger.

On August 22nd she was again admitted complaining of weakness and slight cough. No change in her general condition could be made out and the glands were no larger than before. Nothing abnormal was detected in the chest, and the blood picture was practically unaltered. The cough rapidly cleared away, and after a week the patient insisted on again leaving.

Twenty days later she was admitted for the third time suffering from extreme debility and dyspnœa. She was on this occasion unable to walk, and had to be carried into the hospital.

On examination her whole appearance was found to have undergone a great change. The face was congested and œdematous, the veins of the neck distended, and the glands on both sides were enlarged to five or six times their previous size, while the skin over them was dusky and showed dilated cutaneous veins. They were also now tender on pressure, and had apparently fused with one another. The glands in both axillæ and under the pectoral muscles were also enormously enlarged, and on the left side filled up the entire axilla, where they caused pressure upon the axillary vein, showing itself in œdema of the left arm. The pulse also on the left side was weaker than on the right and the blood pressure measured 10 m.m. lower. The inguinal glands shared in the general enlargement, but not to the same extent. The spleen could not be felt.

On the left side of the thorax a large pleural effusion was present, causing slight dextrocardia, and there was absolute dulness on percussion all over the manubrium sterni. Loud tubular breathing also was audible at the back, over the root of the right lung, pointing to enlarged bronchial glands. Abdominal organs normal; slight œdema of legs and lumbar region; urine much diminished, contained a trace of albumin.

The red blood corpuscles remained persistently increased, averaging 5,100,000 per c.m., with, however, some polychromatophilia, and 70 per cent. of hæmoglobin. The white cells were still diminished, the highest count being 6,500 per c.m. The following represents a typical differential count:—

Neutrophile cells,	65·7 per cent.
Eosinophiles,	3 per cent.
Lymphocytes,	12·3 per cent.
Hyaline cells,	19·0 per cent.

Several of the hyaline cells were unusually large, and contained divided nuclei.

Eighty ounces of clear fluid was removed from the pleural cavity on the day of admission, but it again rapidly collected, and had to be withdrawn almost every third day. Arsenic was prescribed in large doses, and a general stimulating treatment adopted, but the patient rapidly lost ground and died three weeks after admission. During her period in hospital the glands continued to enlarge and the superficial veins of the chest became very prominent.

Autopsy.—Most of the glands in the neck were found to have burst their capsules and to have fused with one another, and also to have infiltrated the surrounding tissues. They were white and rather soft on section, presenting a shining smooth appearance. Some of the axillary glands had also become diffused, but many of them still retained a well-defined capsule. The whole of the superior mediastinum was filled with a large greyish white mass of irregular outline, and extending into the roots of the lungs on both sides were numerous enlarged lymphatic glands. The mesenteric glands were unaltered, but all of the aortic glands, and the glands at the hilum of the liver were enlarged, many of them being about the size of walnuts. The glands along the common and external iliac arteries were enlarged, forming masses which projected from each side into the pelvis and considerably diminished the size of that cavity. The inguinal glands also were big, and two or three of them had extended beyond the limits of their capsule. There was no enlargement of the tonsils or pharyngeal lymphoid tissue, but the agminated follicles of the ileum were hypertrophic and unusually pale in appearance. The stomach mucous membrane showed thickening here and there with erosion caused by the breaking down of lymphoid masses. The bone marrow of both femur and tibia was fatty right up to the extremities. The heart was rather flabby, and contained a small amount of fat within its fibres; the left lung was partially collapsed owing to the presence of a serous pleural exudate, but the azygos veins were healthy. The spleen, normal in size, was rather hard and firm; the Malpighian corpuscles were prominent, and three or four scattered whitish nodules about the size of a pea were present within its substance. The liver, pancreas, adrenals, and thyroid body were apparently normal. The kidneys were somewhat fibrosed.

Microscopical examination.—Sections were made from several of the glands and from the mass in the anterior mediastinum. These presented the typical appearance of a soft lymphosarcoma, but showed irregular areas of necrosis all over the section. The section from the thymic region showed a tendency to lobular arrangement, and some fatty degeneration was noticed. Around the necrotic areas there was here and there a distinct overgrowth of hyaline connective tissue, and the walls of all the blood vessels were thickened and hyaline. Scattered irregular lymphosarcomatous nodules were found in the lung even at places far removed from the hilum. The corpuscles of the spleen were all enlarged, but did not differ from their usual appearance, except that the centre of many of them showed necrosis. Peyer's patches also exhibited the signs of simple overgrowth. Some accumulations of lymphoid cells were found along the blood vessels of the pancreas, but the liver, kidney, adrenals and thyroid were quite free of lymphatic nodules.

Before attempting now to place the above described case under any definite heading in our nomenclature of disease, it may be well to briefly summarise the current views regarding lymphosarcoma, and its relations to and differences from Hodgkin's disease. Sternberg in a recent authoritative summary, in which he quotes largely from Kundrat's classical paper, makes the following statements in reference to the former disease. Lymphosarcoma he defines as a tumour formation commencing in and involving principally the adenoid structures of the body. Its spread is principally along the lymphatics to neighbouring lymph glands, mucous or serous membranes, and it always sooner or later involves adjacent tissues by extending beyond the limits of the glandular capsule. It does not, however, he maintains, ever become so generalised as do the masses in leukæmia and Hodgkin's disease, and furthermore retrogressive changes in the sense of fatty degeneration or necrosis occurs only very rarely, and are then never widely spread. As far as the blood picture is concerned, he states that nothing conclusive can be yet affirmed, but in almost all recorded cases a marked leucocytosis has been present with relative diminution in the lymphocyte cells, though in one case an increase of the lymphocytes was found. Changes in the spleen and marrow are slight, at most consisting in the formation of small whitish nodules in the pulp of the former. The difference between the above picture and Hodgkin's disease as usually described is obvious. In the latter condition there is at first cellular and later fibrous hypertrophy of the glands, and the glandular capsule is never broken down. Cellular necrosis and hyaline transformation of connective tissue is the rule; lymphoid nodules appear in many internal organs; the spleen is usually much altered, and the red marrow may become lymphoid in structure. Anæmia, as in lymphosarcoma, is usually present, but in most cases leucocytosis is absent. The differences, however, tend to disappear when it is admitted, as is done by Sternberg, that lymphosarcoma may take origin in glands already enlarged in Hodgkin's disease, and in any case the clinical picture of the processes so closely resemble one another, that even the clinician of today may find it hard to remove from his mind the idea expressed by Dreschfield in 1892 that acute Hodgkin's disease is lymphosarcomatosis.

To return now to my case, the microscopical examination of the growths at once classes it as lymphosarcoma, but on the other hand the history of slow growth for two years, commencing with the inguinal glands and proceeding with simultaneous involvement of the neck and axillary glands, points more to Hodgkin's disease, as do also the following facts:—(1) The almost universal involvement of the lymph glands of the body, the mesenteric glands alone escaping as is common in Hodgkin's disease; (2) the blood picture showing leucopenia, with relative increase of mononuclear cells, especially of the hyaline type, and at first a relative increase of eosinophiles; (3) the occurrence of extensive areas of necrosis in the glands, along with thickening of blood vessel walls and overgrowth of hyaline connective tissue; (4) the appearance of the lymphatic tissue of the intestine and spleen, showing simple hypertrophy, without sarcomatous elements. The thickening and erosion of the stomach wall is also by no means unusual, nor can the escape of liver, kidney and bone marrow be regarded as uncommon.

To reconcile, then, the microscopical finding with the accepted view of the essential distinction between the two diseases, one must assume that this was a case of lymphosarcoma, occurring suddenly and spreading rapidly in an individual, who had been already affected by Hodgkin's disease for a couple of years, or else regard it as being from the beginning a very unusual variety of true lymphosarcoma. After a careful clinical and pathological study of this case and of others of chronic lymphadenoma, I can subscribe to neither of those views, and at the risk of appearing retrograde, must affirm my belief that lymphosarcoma and acute Hodgkin's disease are one and the same process; and that the case recorded was one of this disease, whatever name we may employ to designate it.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, NOVEMBER 10TH, 1905.

The President, Mr. CLUTTON, in the Chair.

DR. CHARLES W. CHAPMAN read a paper on

THE AFTER-HISTORY AND POST-MORTEM RECORD OF A CASE OF CARDIAC SYPHILOMA, SHOWING BRADYCARDIA AND OBSTRUCTION OF THE INFERIOR VENA CAVA.

The subject of this communication is that of a man who, when first seen in 1897, complained of palpitation and syncopal attacks. It was noticed that the veins of the abdomen were greatly dilated. The patient was shown at a clinical evening of this Society, and a paper was read on the case during the following session. Both are reported in Vols. 32 and 33 of the Clinical Society's *Transactions*. The patient, a man, was æt. 48 when first seen; he had had a small itching sore in 1877, but no secondary symptoms; treatment had been of short duration only. There was in 1897 a lump at the back of the neck the size of half a walnut. A diagnosis of obstruction of the inferior vena cava from gummatous deposit was made, and mercurial treatment followed by iodide of sodium adopted. Under these measures the nuchal tumour disappeared, and the syncopal attacks disappeared in the course of a few weeks. During the last eight years the patient was more or less constantly under treatment as an out-patient, and it was noticed that suspension of the use of specific remedies for two or three weeks was always succeeded by a failure in the general health. He was last seen at the hospital in June last, shortly after which visit he had suppurative appendicitis, and was admitted into the London Hospital, where he died of peritonitis. *Post-mortem.*—The abdomen was covered with varicose veins. There was a small patch of obsolete calcareous tubercle at the apex of the right lung. The root of this lung with the neighbouring large vessels, glands and mediastinal tissues were firmly matted into a mass of fibro-calcareous material. In the base of the right lung the rings of the larger divisions of the bronchi were calcified. The pericardium contained an excess of clear fluid. There was much epicardial fat over the right ventricle. Over the left ventricle and auricle the visceral pericardium was thick and opaque in places. The heart, periform in shape, the right side being about the same size as the left; it weighed fifteen ounces. The heart muscle was brown and tough, with visible strands of fibrous tissue running through it. Both ventricles were dilated. The right auricle was dilated and contained a small black clot. The cavity of the left auricle was greatly diminished and constricted in its middle to a ring which just admitted the tip of an index finger. The cause of the narrowing was a dense mass situated beneath the endocardium. This condition of calcification affected the whole circumference of the left auricle, the inter-ventricular septum and first inch of aorta being in all places deep. The valves were pliant, but just above the mitral ring the left auricle was narrowed by the calcareous mass already described. The coronary arteries were narrowed at their orifices, but further on were unchanged. The aorta had many patches of atheroma. The left testicle presented a typical diffuse fibrous gummatous condition. The liver was enlarged and indurated, and the kidneys normal.

SUPPURATIVE PYLEPHLEBITIS DUE TO A SUPPURATING MESENTERIC GLAND.

DR. FRANCIS HAWKINS read notes of a case of suppurative pylephlebitis in a boy, æt. 12. The patient, fifteen days before admission to the Royal Berkshire Hospital, had an attack of vomiting followed four days later by a sudden chill with vomiting and subsequent diarrhœa, which it was stated lasted twelve days. *On admission*, there was pain and tenderness on pressure one inch to the right and a little above the umbilicus, and some tenderness over the left half of the epigastric region. There was no jaundice. There was no vomiting; the bowels were constipated and relieved only by enemata. For six days after admission, beyond the fact that the case assumed a condition of pyæmia, and that nearly all organs except the liver could be excluded as being diseased, there was no definite sign that the liver was the seat of abscesses. But on the sixth day a definite swelling appeared apparently somewhat suddenly in the epigastric region on the left side. The patient died four days later. At the autopsy, the portal vein was seen to be thrombosed and suppurating, and multiple abscesses were found in the left lobe and the right lobe contained two small abscesses. The mesenteric glands were enlarged, several were in a state of suppuration, and one was of a brownish-black colour and discharged extremely offensive pus. The spleen was enlarged but contained no abscess. The Clinical Research Association sent the following report:—"Direct examination of this pus reveals the presence of a considerable mixture of organisms, but neither tubercle bacilli nor pyogenic cocci can be found, and the only organism detected in cultures is the Bacillus coli communis. There is nothing in the structures of this mesenteric gland to throw light on the suppuration in the liver. Its tissues are much softened and the lymphatic channels are dilated from recent absorption." Dr. Hawkins pointed out the rarity of such cases, and considered that the suppurative pylephlebitis was secondary to the necrotic mesenteric gland.

Dr. De Havilland Hall described an autopsy he had witnessed that afternoon on a similar case, secondary, however, to appendicitis. He remarked on the absence of jaundice in Dr. Hawkin's case, which he considered unusual.

Mr. Charter Symonds said that in his experience jaundice had been exceptional. He gave an account of a case he had had recently. The patient suffered from sleeplessness, and had had a rigor at the outset of her illness; otherwise she was a mild case of appendicitis, and so was not operated on until the fifth day, when another rigor occurred. The local appearances at the operation were such as to cause fear of venous infection, so that the surrounding tissue was freely removed. The appendix was situate near the median line and high up on the mesentery of the ascending colon. The after-course was uneventful, save for sleeplessness and mild pyrexia, until the tenth day, when symptoms of pylephlebitis supervened, and proved fatal in a little while. He drew special note to the fact that the appendix might cause infective pylephlebitis, and yet not attract attention at the autopsy.

Mr. Walter G. Spencer described a case which he had saved by draining the gall bladder, and was of opinion that this might be not infrequently possible in the early stage of the disease.

Mr. Symonds thought the term "pylephlebitis" should be limited to cases of venous suppuration, which were always fatal, and should not include, as Mr. Spencer used it to include, cases of cholangitis, which were similarly accompanied by rigors, enlarged liver and septic temperature.

Dr. Norman Dalton remarked on the co-existence of the infections, bile duct and portal vein.

Dr. A. E. Garrod referred to a paper of Dr. Langdon Brown in the St. Bartholomew's Hospital Reports. Of forty-three cases, 43 per cent. only had jaundice.

Dr. Hawkins replied.

SUCCESSFUL CASE OF SPLENECTOMY FOR RUPTURE.

Mr. Graham Simpson showed a man, æt. 27, whose spleen he had excised for traumatic rupture. The patient had fallen twenty feet, striking his left side as he fell; he was at once admitted to the Sheffield Royal Hospital for a fracture of the left femur; he did not show any signs of an intra-abdominal catastrophe till four hours after the accident. A diagnosis of rupture of the intestine was then made, and the abdomen opened at once; the abdominal cavity contained much blood, and some difficulty was experienced in finding the source of the bleeding. On examining the spleen, its lower third was found to be nearly torn off, and as the rupture involved the hilum, the organ was excised. The man made a rapid recovery, in spite of the fact that the wound suppurated badly. The only points to note were a temporary anæmia and leucocytosis, delayed union of the fracture of the femur (twelve weeks), and slight enlargement of some of the lymph glands. Mr. Simpson made some remarks on the diagnosis and treatment of this condition, basing his observations on one hundred cases he had collected. He suggested that the three points of importance in the diagnosis were: an accurate history of the accident, the signs of internal hæmorrhage, and the localising signs. Of these last he attached most importance to Mr. Ballance's observation that on suitably changing the position of the patient the dulness of the right loin shifts, but not that of the left. He divided the cases up into four groups:—(1) The patient dies at once, or within a few minutes of the accident (spontaneous rupture); (2) the onset of symptoms is greatly delayed—from twenty-four hours to fifteen days. This delay may be due to clotting or to the bleeding being at first subcapsular and subsequently bursting through the capsule. (3) The majority of cases, the symptoms show themselves in from one to twenty-four hours. (4) A few cases where the symptoms of a rupture of the spleen have shown themselves, and have gradually passed off without operation. He recommends that all these cases should be operated on; those of the fourth group because in two cases the blood later became infected. As regards the operation, he thought splenectomy would usually be found necessary, as the ruptures are often very extensive, and frequently involve the vessels of the hilum. He concluded by discussing the causes of failure of the operation, and the sequelæ of removal of the spleen.

Mr. Clutton was in favour of tamponnage wherever possible instead of splenectomy.

Mr. Crisp English described a similar case in which the symptoms were very equivocal for three days after the accident, when extensive collapse appeared suddenly. Although the patient was pulseless, he operated and she made a good recovery. The blood-count, total and differential, was quite normal three weeks after the operation, and continued so for eighteen months.

Dr. Ernest Jones asked for details of the differential count in this case, in view of the great theoretical interest of the operation as bearing on the question of the origin of the white corpuscles. He referred to experimental researches carried out in Russia by Kurloff, which showed that during the first year a hyperlymphocytosis appeared, which was followed in the second year by eosinophilia.

Mr. Simpson, in replying, agreed with Mr. Clutton as to the value of tamponning wherever possible. It was not often possible on account of the frequency of implication of the hilum by the tear, and the extreme haste with which the procedure had to be carried out. As to the blood-count, the leucocytosis due to suppuration, and which reached 44,000 at one time, soon subsided. Thirteen months after the operation several careful counts were done, and their average, two hours after a meal, was reds, 4,760,000; whites, 6,500, of which 57·6 per cent were polymorphonuclears, 1.2 per cent. transitional cells, 15·32 per cent. large hyaline cells, 21·14 per cent. small lymphocytes, and 3·89 per cent. eosinophiles. No mastzellen or normoblasts were present.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

Meeting Held Friday, November 3rd, 1905.

The President in the Chair.

The President made some introductory remarks.

GASTRIC SURGERY.

Mr. Gordon, having briefly referred to cases of gastric perforation, gastrectasis due to simple pyloric stenosis, and recurring hæmatemesis went on to discuss at some length the surgical treatment of chronic ulcer of the stomach as apart from its complications. He stated that this was a subject about which there was still room for difference of opinion. A conclusion was to be arrived at by considering chiefly three things—*i.e.*, surgical experience, medical experience, and the relative risks of operative and non-operative methods. He had investigated the after history of a number of cases treated by physicians in a general hospital, and the result of this investigation seemed to show that such treatment was generally unsuccessful. In discussing relative risks, he gave it as his opinion that there was just now a tendency to overrate the frequency of perforation and fatal hæmorrhage; and a tendency, on the other hand, to under-estimate the dangers of gastro-enterostomy. He described a remarkable case in which a hernia had occurred after a posterior gastro-enterostomy. A considerable length of jejunum had passed under the anastomosis from right to left (not into the lesser sac of peritoneum). The patient recovered, but the ultimate result was not likely to be good. Mr. Gordon, in conclusion, gave an account of his experience of the surgical treatment of gastroptosis. He pointed out that this condition was not necessarily a part of a general neurotic state, and further that the neurasthenia, when present, might be the primary fault and might develop secondarily. Gastro-enterostomy was likely to fail in cases primarily neurotic, but might succeed where the prolapse of the stomach was primary.

GASTRO ENTEROSTOMY.

Subsequently Mr. **McArdle** communicated a paper on the above subject, and said that the frequency of post-operative troubles rendered it imperative to study every detail in the after history of cases of this kind. He alluded first to a case in which he carried out the anterior operation for the relief of violent hæmorrhage from the stomach. This was his first experience of the operation, and he selected this method on account of complicated adhesions, which would render the posterior operation a very long one. The immediate result was not very favourable; a vicious circle was established, and persistent vomiting of bile was the result. Four weeks after the first operation he opened the abdomen, and found coils of the jejunum twisted out of place and adherent. The freeing of adhesions, with reposition of the intestines and fixation, resulted in complete relief, and the patient is now, thirteen years after operation, in perfectly sound health. From this time Mr. McArdle has always carried out the posterior operation, and to prevent any chance of looping or torsion on the small intestine he has left the shortest stretch of intestine possible between the end of the duodenum and the point of anastomosis. He related cases to illustrate how this type of procedure prevented the occurrence of the distressing symptom referred to. He then related cases which had been carried out by other operators, in which long stretches of the jejunum had been left to sag downwards into the abdomen, or become twisted upon themselves. He detailed the methods necessary in these cases to relieve the symptoms dependent on the formation of the vicious circle. He concluded his communication by advocating posterior gastro-enterostomy with a short loop of the jejunum as the most perfect method, as, since the adoption of this method in 1904 he has never had any instance of the development of a vicious circle in his cases, all of which were carried out with Murphy's button, and without any mortality. In the discussion which followed, Mr. Edward H. Taylor alluded to some points of importance in the operation of posterior gastro-enterostomy, notably, the advisability of leaving a short loop of bowel between the duodeno-jejunal flexure and the site of the anastomosis, and of suturing the jejunum to the stomach for some distance on each side of the latter. By adopting these precautions the risk of a vicious circle being established was almost nil. He referred to a type of female stomach which he considered not uncommon, and believed to be intimately associated with tight lacing, viz.—one in which the gastric orifices approximated each other, the lesser curvature being sharply bent upon itself and the pyloric segment of the viscus represented by a large dependent pouch.

Mr. **Jameson-Johnston** discussed the relative values of douching and sponging in cases of extravasation of the stomach contents. The choice of procedure, he thought, depended on the amount of the latter. With a limited extravasation he favoured sponging, if extensive he preferred douching.

Mr. **Wheeler** referred to the views put forward by Moynihan on the occasion of the recent meeting of the British Medical Association at Leicester.

Mr. **Haughton** stated that he had had a number of cases with considerable neurotic tendency, in which he had found adhesions giving rise to mechanical obstruction and accompanying enteroptosis. Many individuals supposed to be neurotic might really have a physical cause for the disorder in adhesions. In one of his cases a vicious circle had resulted from the jejunum being nipped by the margins of the aperture in the transverse mesocolon. He employed a Murphy button for effecting an anastomosis between the two limbs of the intestinal loop, but death followed in consequence of gangrene outside the zone of pressure.

Mr. **Kennedy** expressed himself in favour of Murphy's button, as its employment resulted in the formation of a round punched out hole, whereas the suture method without this mechanical appliance left merely a slit.

The **President**, in discussing the communications, referred to the widely varying results which were obtained after similar operations for similar complaints. He would like more information on the subject of feeding after operation; he always felt some what uncomfortable until seven days had elapsed.

Mr. **Gordon**, in reply, stated that it was his practice to begin feeding practically at once. Sips of hot water after the operation were followed next day by teaspoonfuls of albumin water every hour. From this on the amount of liquids given was rapidly increased, and solid food was allowed after the tenth day.

Mr. **McArdle**, in reply, stated that he allowed as much fluid as the patient desired from the start. He always employed the Murphy button, and alluded to the rapidity with which it could be introduced.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held Thursday, November 9th, 1905.

Mr. **Priestley Smith**, F.R.C.S., **President**, in the Chair.

Dr. L. B. Nias and Mr. **Leslie Paton** read a preliminary note on

THE VALUE OF THE OPSONIC INDEX FOR TUBERCLE IN PHLYCTENULÆ.

The research was suggested by Dr. Wright, who observed that frequently a crop of phlyctenulæ developed in patients undergoing inoculations with tuberculin. This suggested the investigation of the opsonic index in such cases in the hope that it might throw some light on the question of the tubercular nature of the disease, and whether it was exogenous or endogenous in origin. The determination of the opsonic index was done by Dr. Nias in 20 cases of the disease. Five cases of other forms of conjunctivitis were used as controls, and seven of the 25 cases were simultaneously examined to determine their opsonic index for staphylococcus. The results showed in striking form variations from the normal in the tubercular index of the cases of phlyctenular conjunctivitis; practically normal indices for the other forms, and practically normal indices for staphylococcus in the majority of cases tested. In one case in which there was fairly advanced phthisis, both the tubercle and also the staphylococcus indices were lowered.

Mr. **Nettleship**, in a note on

SOME VARIETIES OF ALBINISM IN MAN,

mentioned the following:—(1) Albinism of hair and skin with normal eyes; (2) albinism of eyes with hair that, originally white, became yellow or red or quite brown about the age of puberty; (3) albinism of choroid only with nystagmus and defective sight; (4) Progressive pigmentation of the albinotic eye as in class two, but occurring too long after birth to allow of any improvement of sight; (5) pied albinism—*i.e.*, congenital absence of pigment from certain areas of skin. In incomplete human albinism the whole uveal tract was entirely free from pigment, while the retinal epithelium was more or less pigmented. Manz proved this in 1878, and Usher had confirmed this in some sections (shown at the meeting) from the eyes of two individuals. In sections of the iris of a completely albinotic man the author had found the posterior epithelium, as well as the iris itself, devoid of any trace of pigment.

In discussing the question of

COLOUR BLINDNESS IN WOMEN,

Mr. Nettleship mentioned five familes in which one or more females were congenitally colour blind; in four of them some of the males were also affected, and in one, the family history was not obtained. He pleaded for a systematic search for colour blindness in females, especially in families affected by it, so that we might know for certain whether the current opinion that we meet one female to forty males affected is correct, and whether also it passes from affected father, through unaffected daughter, to grandson as in hæmophilia. It was pointed out that slight degrees of colour blindness, especially if intentionally concealed, would be more difficult of detection in women than in men.

Dr. Arthur J. Ballantyne gave a lantern demonstration of a case of

METASTATIC SARCOMA OF THE OPTIC NERVE AND RETINA.

The patient was a woman, æt. 58, who had right-sided hemiplegia, parosis of the left internal rectus, and blindness of the left eye. All these symptoms were said to have come on within one week. The ophthalmoscope showed a yellowish mass which was oval in shape projecting from the disc which was completely concealed by it. Its diameter was about three times that of the disc, and there were also a number of flame-shaped retinal hæmorrhages in the retina. The patient died, and the necropsy revealed patches of softening in the pons and corpus striatum. In addition to this there was a sarcomatous mass in the mediastinum and root of the left lung which was probably the primary growth. Metastatic growths were found distributed almost all over the body. A mass was found in the optic nerve, this had pushed its way through the lamina cribrosa into the eyeball, and it was this which was seen ophthalmoscopically. The greater part of this growth was necrotic, but parts of it stained well. The metastatic growths were ascribed by the author to emboli which had reached the blood stream through the walls of the pulmonary vein.

HARVEIAN SOCIETY OF LONDON.

A Clinical Meeting was held on November 9th, at St. Mary's Hospital, Paddington,

The President, Mr. C. B. Lockwood, in the Chair.

Dr. Wm. Hill showed a case of right facial paralysis of three years' duration with contracture on the same side. Only slight improvement had taken place under the administration of strychnine.

Dr. J. Broadbent also showed a case of right-sided facial paralysis of thirty years' standing with contracture. Only slight recovery in the orbicularis palpebrarum was to be noticed.

Dr. Wm. Hill showed a young man with extensive tubercular disease of the right temporal bone who had been operated upon several times. On the last occasion one month before, the *dura mater* in the middle fossa of the skull was exposed and removal of bone had been effected down to the lateral sinus. The facial nerve was uninjured. There was no attempt at repair owing to the poor health of the patient. A sojourn at Margate was advocated. Mr. Crisp English suggested the use of formalin locally and favourable surroundings of the country.

Dr. J. Broadbent showed a man of robust appearance and enjoying good health whose viscera were transposed—the heart to the right side and the liver to the left.

Dr. J. Broadbent also showed a case of enlargement of the liver—either cirrhotic or due to secondary malignant deposit. He had had his right testicle removed owing to the presence of a tumour, which was found to be sarcomatous and contain adrenal growth. The President and Dr. Spilsbury referred to the interesting question of the presence of adrenal " rests " in the inguinal canal, the hilum of the kidney along the ureter and in the liver.

Mr. Clayton Greene showed a bulky man from whose right ureter a small uric acid stone had been removed on Sept. 23rd. He had renal colic on Sept. 18th, followed by right epididymitis and four days' anuria. When cystoscoped on Sept. 23rd, the right ureter appeared healthy, and white flakes were seen exuding from the dilated mouth of the left ureter. After the operation, urine came out of the right loin, but none was found in the bladder for eight days. The wound healed on October 20th. A second cystoscopy showed pus escaping from the left ureter. The questions of the possibility of recurrence of the anuria and of an operation on the left kidney were discussed.

Mr. Daniel thought the epididymitis was no doubt septic, the man having slight prostatic enlargement which is associated with the presence of micro-organisms.

The President suggested the use of a separator to determine the secretion of the two kidneys and referred to a case illustrating the importance of this procedure.

Mr. Clayton Greene also showed a case of extensive aneurysmal varix in the right forearm of a young woman, involving the radial, ulnar and interosseous vessels, and probably of congenital origin. He contemplated doing arterial ligation, and spoke of possible amputation.

The President referred to a case of aneurysmal varix, and said the condition appeared to be more common in young women, and advocated some form of elastic bandaging.

Mr. Crisp English suggested the successive ligature of vessels supplying the tumour and then referred to the possible advantage of elastic bandaging; he urged time and patience and the trial of all possible measures before thinking of amputation.

Mr. Maynard Smith showed a case of enlargement of both parotid glands in a man, the right dating eighteen months, the left ten days. No calculus was found. He thought the cause was oral sepsis, from carious teeth, etc.

Dr. J. Broadbent and Dr. Wm. Hill discussed the case.

Dr. Cautley deprecated surgical intervention in the absence of obvious indications for operation and referred to a case in point which has lasted seven to ten years without much discomfort.

Dr. Cope showed for Dr. Leesan anomalous case of tabes in a man, æt. 59. He had numbness of the legs and cramp three months before. Ataxy developed one month ago, and on admission to the hospital he could not walk without support. The knee jerks were absent and one pupil was sluggish. There were tremors of the head of ten years' duration. No optic atrophy, but limitation of the field of vision in the right eye.

Dr. Cope, for Dr. Lees, showed a young man who was admitted into the hospital for hæmoptysis. He had a loud diastolic musical murmur at the cardiac base and signs of phthisis at both apices of the lungs, confirmed by examination with the X-rays.

Dr. Sydney Phillips said that no deduction as to the condition of the aortic valves could be drawn from the musical character of the murmur.

Dr. Cautley referred to the interest of a diagnosis of tubercle of the lungs founded on X-ray evidence.

Dr. Cope also showed for Dr. Lees a young woman suffering from cerebral dipligia. She had impaired gait, difficulty of articulation, percavus with talipes equinus, athetoid movements with incoordination of arms, intentional tremors of hands and upper limbs; incoordination of legs and increased knee jerks. She was mentally backward. There was a history of difficult and delayed birth.

Dr. **Cautley** said the case seemed to be due to meningeal hæmorrhage from the history, and the prognosis in these cases was worse than in those due to developmental error.

Mr. **Laming Evans** suggested that division of tendons would improve the walk; and in reply,

Dr. **Cope** said that Dr. Lees thought meningeal hæmorrhage accounted for the birth palsy, and he agreed that operation might correct the equinus.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, November 11th, 1905.

Intermittent Hydrarthrosis.

Intermittent hydrarthrosis is a serous effusion into the joints, and more especially the knee. A similar affection in the hip, the elbow, the wrist, has been observed, but the cases are very rare. A singular characteristic of intermittent hydrarthrosis is its periodicity. Dr. Mauganze has published the case of a patient, æt. 25, with no hereditary antecedents, no blenorrhagia nor syphilis, who woke up one morning with his knee considerably swollen, without any apparent cause. This condition lasted a fortnight without any notable improvement, when, suddenly, the effusion decreased, and complete resolution was obtained in two or three days. A year afterwards the same symptoms returned and lasted ten days and returned twice during the following year.

The cause of this periodic hydrarthrosis was for a long time very obscure. Rheumatism was accused of producing the affection, but very frequently the cases observed were free from any arthritic taint. On the other hand, salicylate of soda had no effect on the effusion. The cause is probably due to tuberculosis.

The treatment naturally consists in local irritation (thermocautery), and especially in general treatment with cod-liver oil, arsenic, sea air, salt baths.

Acute Rheumatism.

The classical treatment of acutearticular rheumatism has been large doses of salicylate of soda in Vichy water. But lately this treatment, which, after all, succeeds very well, has been improved upon by some of our German *confreres*, and notably by Mendel, and imitated by a few of our French professors. This new treatment consists in the injection into one of the veins at the elbow of a solution of salicylate of soda.

Salicylate of soda, 2 drachms;
Cafeine, ½ drachm;
Water, 1½ ounces.

Two cubic centimetres (two hypodermic syringesful) are injected each day into the vein. The *modus operandi* is not difficult, nor complicated. A bandage is placed above the elbow and drawn tightly, as in a case of phlebotomy. When the needle is inserted the bandage should be removed and the liquid injected; if a subcutaneous swelling occurs, the needle has not entered the vein. Care should be taken to expel the air from the syringe before making the injection. Max Behr strongly recommends this intra-venous treatment. Cases of lumbago and articular rheumatism have been cured in a very short time by the treatment. The salicylate of soda may also be injected directly into the synovial cavity in cases of subacute rheumatism, monarticular with hydrarthrosis, at the dose of from 3 to 5 cubic centimetres.

Adrenaline and its Preparations.

If adrenaline, says Prof. Huchard, has not given all the results expected of it in cases of hæmorrhage, it is still prescribed with a certain success for its vasoconstrictor properties. The solution used is that of hydrochlorate of adrenaline, 1 in 1,000; it is employed in mixture or enemas or subcutaneously, and externally in applications or instillation.

In hæmoptysis adrenaline has been injected in 10-drop doses twice or three times a day, but it cannot be relied upon. In hematemesis, however, it succeeds better. Every four hours ten drops are given in a little water. The same may be said of intestinal hæmorrhage of any cause. Here enemas take the place of the mixture, and the dose is about the same (10 to 12 drops).

In hæmorrhoids, adrenaline has been found very useful, especially where they are painful and procident.

Cocaine, 1 gr.;
Sol. of adrenaline (1 in 1,000), 30 minims;
Water, 1 oz.

A plug of absorbent wool steeped in this solution and applied to the region and covered with oil-silk. The application can be renewed every three hours until relief is obtained. Where the hæmorrhoids are not procident, the adrenaline can be introduced into the rectum in the form of ointment.

Cocaine, 1 gr.;
Sol. adrenaline, 30 minims;
Vaseline, 4 drachms.

Local anæsthesia :—

Hydroch. of morphia, 1-10th gr.;
Stovaine or cocaine, 1 gr.;
Chloride of sodium, 2 gr.;
Sol. of adrenaline, 1 drachm;
Water (sterilised), ad, 1½ oz.

An injection of 10 cubic centimetres (a Pravatz syringe holds 1 cubic centimetre) is sufficient to procure anæsthesia in from five to seven minutes.

In certain affections of the eyes adrenaline is frequently employed. One drop instilled into the eye three times a day furnishes excellent results in conjunctivitis.

In iritis the following preparation is frequently employed :—

Sulphate of atropine, ½ gr.;
Hydrochl. of cocaine, 2 gr.;
Sol. of adrenaline, ½ drachm;
Water, 2 drachms.

One drop in the eye every three hours.

Glaucoma :—

Hydrochl. of pilocarpine, 2 gr.;
Sol. of adrenaline, 1 drachm;
Water, 1 drachm.

For extraction of foreign bodies :—

Cocaine, 2 gr.;
Sol. of adrenaline, 10 mm.;
Water, 2 drachms.

One drop every two minutes during ten minutes.

Hæmorrhagic metritis :—

Internally, ten drops of the solution three times a day.

Externally, a similar amount applied to the os by a brush.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, November 12th, 1905.

Cutaneous Tuberculosis.

At the Gesellschaft der Aerzte, Kraus related the effect of his experiments with apes of the mucacus tribe, which he had injected with tubercle and syphilis. Those injected with syphilis produced a primary form which, after a few weeks, developed a pustular exanthema on the trunk and limbs; but no spirochetæ were to be discovered.

An example recorded was that of a healthy monkey, vaccinated in the upper eye-lid by scarification. Sixteen days after a large, hard, dark, red nodule appeared which soon extended to the surrounding glands as small tubercles, and spread over the whole face. Lymph taken from these glands and injected into other parts of the healthy skin produced the same morbid changes in another healthy animal.

The histological condition was again examined, and still the first and second animal gave no indication of spirochetæ, although tuberculous bacilli were present in stroke cultures. In the first animal there were decided cutaneous syphilitic symptoms which were not so pronounced in the second, and which disappeared altogether in the lower forms of apes. There is a tuberculous form of the skin which may resemble syphilis, but no specific can be obtained from it.

Rieht said these results accord very closely with others, proving that a skin affection can be produced with the virus resembling syphilis, but not identical. The same failure exists with regard to vaccinating tuberculosis on the cutaneous surface, either in miliary or verrucosa cutis.

Congenital Contractions.

Handek showed a child, æt. 2½, with congenital contraction of the hands without the presence of any osseous defects ; manus vara, analogous lopedis vara. In addition to this there were a number of other congenital defects, such as squinting, small formation of the bulbi, and nystagmus. The etiology in this case he said, was hereditary, as the father had a similar defect; although the small quantity of amniotic fluid may have contributed in some measure to its production. Handek was of opinion that the cerebral affection was the real cause of the deformity, although the contractions may have been aggravated *intra utero.*

After this A. Singer showed his hand vibration massage apparatus, which is named "venevici," and has already been introduced into England. It weighs 600 grms., and is easily worked with the hand. It is an effective instrument for producing vibratory massage on any part of the body.

Septic Pneumococcus.

Vlach contributed an article on a typical case of croupous pneumonia, which produced septicæmia. He performed lumbar puncture and obtained from the exudation a large quantity of diplococci lanceolati. After a long physiological discourse, he assured his hearers that the spread of the infection from the lung was due to a degenerative change in the vascular system brought about by a long drinking habit.

Foreign Bodies in the Œsophagus.

Hacker gave the history of thirty-eight cases from whom he had removed foreign bodies from the œsophagus with the assistance of the œsophagoscope. In many of the cases, bleeding from the torn mucous membrane is all that could be observed, although the foreign body was still present. The *modus operandi* was conducted in adults by applying a 20 per cent. solution of cocaine to the mucous membrane; in children, however, general narcosis had to be performed.

Ischiatic Scoliosis.

Lorenz gave a short description of the theory and practice of ischiatic scoliosis, which he considered due to a spasmodic reflex action in the mechanical straining of the affected nerve. The spinal column of the lumbar region was convex by muscular plasma towards the affected side. Massage and stretching gymnastics were to be avoided in these cases, as he considered the best treatment was to fix the lower part of the pelvis and the limb of the affected side in a flexed position as far as the patient could bear it.

Appendicitis Operation.

Riedel said his operations for appendicitis had a mortality of 7½ per cent. He recommended the zig-zag incision commencing 1½ cm. above Poupart's ligament, splitting the oblique externis, separating the oblique internis, and splitting the transversus. He then carefully opens the peritoneum, applies a double ligature to the appendix and stretching the mucous membrane of the stump of the cæcum, supports it with four silk and five catgut stitches. The patient is retained three weeks in bed, and the parts afterwards supported with bandages.

Medical and Pharmaceutical Awards at Liege International Exhibition.

The International Jury of the Liége Exhibition have conferred upon Messrs. Burroughs, Wellcome and Company six Grand Prizes, three Diplomas of Honour, and three Gold Medals for the scientific excellence of their products, including "Wellcome" Brand Chemicals, "Tabloid" and "Soloid" Brand Products, "Kepler" Preparations, "Tabloid" Brand Photographic Chemicals, "Hazeline" Preparations, Pleated Compressed Surgical Dressings, "Tabloid" Brand Medical Equipments, &c.

Operating Theatres.

WEST LONDON HOSPITAL.

Thyroidectomy.-Mr. Swinford Edwards operated on a man, æt. 30, who had been admitted with a swelling in the neck, which he had noticed for the past four years. It was the size of a large fist, and extended across the median line from one sterno-mastoid to the other,whilst the lower border rested on the episternal notch ; it was smooth, and distinct fluctuation could be felt ; it was non-pulsatile. Of late it had considerably interfered with respiration at times. Mr. Edwards said it was clear that this was a case of an adenomatous thyroid having undergone cystic degeneration. The patient having been anæsthetised, a semi-lunar incision was made transversely across the centre of the tumour and the various structures lying in front of it divided, namely, the platysma, the sterno-hyoid and sterno-thyroid muscles on either side. The thyroid was now well exposed, and, after cutting through its capsule, the capsule of the cyst was encountered, there being but little, if any, thyroid tissue between the two. It was now easy with the finger to strip the tissues off the cyst wall, but, on the right side, whilst carrying out this manœuvre under the sterno-mastoid muscle, the cyst gave way and a large amount of dark brownish fluid escaped. The collapsed cyst wall, which had been almost freed, was now dissected out ; in doing this a small piece of the thyroid body on the left side was seen and left behind. There was considerable oozing from the bottom of the deep cavity which required the application of several hæmostatic forceps. The vessels were now tied off and a large drainage tube inserted into the bottom of the wound, the divided muscles were brought together with buried sutures, and the skin wound was closed with silkworm gut. Mr. Edwards said that in this country, as far as his experience went, most cases of enlarged thyroid or goitre proved to be encapsuled adenomata, which afterwards underwent cystic transformation, and their removal was, comparatively speaking, an easy one, as these cysts are easily shelled out if the proper layer, namely, the cyst wall, is exposed, and then the enucleation completed by the finger stripping off it all overlying tissues. This case had to be re-dressed in the first twelve hours, the first dressings having become soaked with blood. This oozing, Mr. Edwards subsequently pointed out, is only to be expected in such cases, and shows the necessity of providing free drainage, a point which was carried out at the time of the operation. The patient, ten days after operation, was convalescent.

ST. PETER'S HOSPITAL.

Enucleation of an Unusually Large Prostate. —Mr. Swinford Edwards operated on an old man, æt. about 70, who had been admitted with a history of stone and enlarged prostate. Mr. Edwards himself had performed litholapaxy on this patient a year previously, and had then expressed an opinion that the man was likely to again suffer with a stone, as he was dependent on catheterisation, and had been so dependent for the last three years owing to prostatic enlargement. Cytoscopy was first carried out under an anæsthetic, with an eight-ounce distension, when a good view of the interior of the bladder was obtained ; there was considerable intra-vesical enlargement of all three lobes of the prostate, but notably of the median. In the posterior prostatio pouch were seen four whitish and facetted calculi ; the fluid was now withdrawn from the bladder and a bi-manual examination of the prostate made; the gland proved large and movable. There being some amount of cystitis present, Mr. Edwards postponed the supra-pubic operation which he contemplated in order that the bladder might be washed out daily with solutions of argent. nitr (2 grs. to pint) and boracic acid, for the purpose of cleansing the viscus. Fourteen days afterwards the patient's condition being in a sufficiently good state to warrant enucleation of the prostate being undertaken, he was again anæsthetised, and the bladder having been distended with fluid, it was opened supra-pubically. In doing this, at least three inches of fat had to be cut through, for not only were the abdominal parietes obese, but there was an unusual amount of fat lying over the bladder in the pre-vesical space. The bladder having been opened, the patient was at once placed in the Trendelenburg position, and the lips of the wound in the bladder held apart by retractors, thus enabling a good view to be obtained of the enlarged prostate and of the calculi. The stones having been removed, an incision one inch in length was made over the right lateral lobe of the prostate through the mucous membrane. The prostate was then enucleated in the usual way, that is to say, by the index finger of the right hand, whilst the gland was pushed up by the middle and index fingers of the left hand in the rectum. The intra-vesical portion of the prostate stripped readily, but the extra-vesical portion proved to be much larger than anticipated, and although it stripped fairly easily where the enucleating finger could be applied, it was so deep and big that three fingers had to be introduced into the bladder whilst the whole hand was buried in the abdominal wound before the prostate could be freed from its attachment to the triangular ligament. The prostate was delivered in three pieces, it having been torn in the process of extraction from the bladder. Looking to the magnitude of the operation, there was comparatively little bleeding, and, after irrigation of the bladder with boracic solution at a temperature of 110° through a catheter introduced per urethram, the patient's pulse was nearly as good as before the operation. The patient was lowered from the Trendelenburg position before irrigation. A large rubber drain, one inch in diameter, was now inserted into the bladder through the supra-pubic wound, the abdominal wound partly closed, and a gauze drain inserted by the side of the rubber tube as far as, but not into, the bladder. Mr. Edwards remarked that, in spite of the magnitude of the operation, he felt he had been justified in the course he had taken, for had he been content to only perform in this instance the litholapaxy, the purpose for which the patient was admitted into the hospital would not have been carried out, as litholapaxy would only have given temporary relief, and the patient would have had to be re-admitted at a subsequent date, with a possible re-formation of the stone. He commented on the large size of the prostate he had just removed, and said he believed it to be one of the largest on record; at all events, it was by far the largest of his series, its weight being 10¼ ounces, and its size fully equal to two small fists. He also remarked on the methods he had employed in this particular case, the points being the position of patient and the use of a knife rather than the finger-nail for dividing the mucous membrane over the prostate. By using the Trendelenburg position a good view of the interior of the bladder could be obtained, which is practically impossible with the patient in the horizontal position; thus the surgeon is enabled to divide with exactitude the mucous membrane under the guidance of the eye. In this way he finds that some little time is saved in starting the enucleation, and this conserves a considerable amount of energy and muscular force, which is likely to be wasted in the process of stripping the organ. Another point in favour of this position, he said, is that the patient's head being low, sudden collapse during the operation is not likely to occur.

Nine days after operation the patient was progressing very favourably.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 15, 1905.

THE HUNTING OF THE DEER.

To teach the avoidance of unnecessary cruelty to the lower animals is to urge a sound moral precept. A maxim of this kind, however, can secure general respect only if applied with consistency to all the relations of mankind with the subordinate animal kingdom. If a man be kind to his fox-terrier, for instance, he should be not less considerate of the anguish he may cause to pheasants and pigeons and deer and horses, and other creatures whom he may find it necessary or desirable to use for purposes of self-preservation. The main underlying factor of all man's relationships with the lower animals is founded upon his assumed right to appropriate their bodies to his own ends, whether these be of a domestic or industrial nature, for purposes of sustenance, for clothing, or merely for self-decoration, or for the gratification of the primitive lust for slaughter that forms the material basis of so-called sport. Under the same ultimate heading falls the claim of medical science that it is entitled to use the bodies of the lower animals experimentally for the furthering of medical science and of promoting and succouring the physical and mental welfare of mankind. Yet some condemn vivisection as a practice of monstrous cruelty, regardless of its motives, which are among the highest conceivable of human ideals. The earnest enthusiast, working in obscure poverty in a remote laboratory. gives up his whole life willingly to the pursuit of knowledge that may one day serve to reduce the sum-total of human misery. Yet he is branded by a noisy knot of sentimentalists as the perpetrator of acts of deliberate and unjustifiable cruelty. The ludicrous inconsistency of this attitude upon the part of persons who sanction bearing-reins, pigeon shooting, rabbit coursing, hunting of tame deer, cropping of dogs' tails, the slaughter of brooding egrets to obtain decorative plumes, and many barbarous acts of wanton cruelty or of sacrifice of life inflicted in the mere wantonness of self-amusement or of vanity are shown. It were fruitless here to travel over this well-worn ground. No justification has ever been established for the unnecessary suffering thus inflicted upon the lower creation. The question of tame deer hunting, however, is constantly before us, and may be discussed with some advantage from the standpoint of consistency. Many zealous anti-vivisectionists are strong upholders of the claims of sport. The Duke of Portland, for instance, condemns vivisection root and branch on the one hand, while on the other he lauds deer hunting to the skies, and even goes so far as to maintain that the hunted animal shares in the enjoyment of the chase. The special exultation of feeling on the part of the quarry certainly leads to the commission of emotional acts of an extreme nature that one does not, as a rule, associate with pleasurable sensations. Not long ago, for example, a fine buck deliberately jumped down some lofty cliffs and was dashed to pieces rather than wait for further pleasurable attentions from the Devonshire pack in the distance. Last week a hunted deer rushed into the village of High Wycombe and in a mad paroxysm of joy attempted to leap the railings that fence the football ground. She was spiked, lifted off bodily into the shelter of the ground, and there found so terribly injured that her throat was cut. These narratives, harrowing as they are to the humane vivisector, fade into insignificance by the scene depicted by an eye-witness as having occurred at Westerham, Kent, on November 7th. A hunted doe, bleeding from mouth and flank, took refuge in the grounds of a girls' school, and was followed by the hounds and some of the huntsmen. The schoolmistress and the children made it their business to protect the poor hunted creature. They warded off the dogs, and after a prolonged dispute the huntsmen dragged away the body of the deer with the schoolmistress clinging to it. The school-children at length gained the victory and actually drove the trespassers out of the grounds. The doe was then promptly carried off and locked up in a gymnasium, where it died a few hours later. These and other facts are testified to by Mr. John M. Robertson. If they are to be accepted they present a picture of cruelty so loathsome and barbarous that it has turned women and children into protesting heroines. The Duke of Portland will do well to investigate and consider this incident, and to inquire whether his energies might not be better directed into regulating the conduct of so-called "sport" than in endeavouring to intimidate and hamper the actions of a body of scientific men whose aim is to protect rather than to destroy, and who are already under strict Government supervision.

MUCOMEMBRANOUS ENTEROCOLITIS.

AMONG those ill-defined conditions which undoubtedly exist, but to which it is difficult to assign a distinctive place in medical nomenclature, membranous colitis, or, as it is more correctly called, mucomembranous enterocolitis, occupies a distinct position. When diseases are not specifically classified they are apt to be inadequately dealt with in current literature, and mucomembranous enterocolitis, which is far from being a rare condition, has suffered a good deal of neglect from this cause. Strictly speaking, it would seem to be more of a symptom-complex than a disease *proprement dit*, but from the fact of its possessing distinctive characters it may conveniently be regarded as an actual disease, especially as its treatment has to be carried out on well-defined lines. A short monograph on the subject has lately been written by Dr. Paul Froussard, of Plombieres-les-Bains, in which the condition is treated of in its various aspects, and distinguished as an entity in itself apart from allied syndromes connected with other specific colon diseases, such as dysentery, tuberculosis, coli-bacillary inflammation, summer diarrhœa, and streptococcal colitis. The characteristic symptoms of mucomembranous colitis are given as constipation, which may at times alternate with attacks of diarrhœa; pain, which is often paroxysmal, and eventually the passage of mucus in the stools, often in a form resembling false membrane. Although these symptoms are characteristic of the condition when it is fully developed, there are many cases in which the disease is abortive or atypical, and it is these latter which tend to mask the occurrence of the complaint, and to confuse it. As predisposing causes are given the gouty and neurotic diatheses and acute affections of the digestive organs, the evidence in favour of constitutional predisposition being strengthened by the tendency of mucomembranous enterocolitis to run in certain families. The local exciting cause, *par excellence*, is gastro-intestinal dyspepsia in its various forms, especially such as follows mental or physical shock or injury. Constipation is, however, the leading initial symptom; indeed, by some writers the pain, tenesmus, and passage of mucous casts are regarded merely as a result of chronic confinement of the bowels. This constipation may be real and obvious or apparent only on close examination, as it may be represented by a series of small, hard motions, occasionally accompanied by diarrhœal flux, showing that the bowel is not habitually and fully emptied. Under the latter conditions it is not infrequent to find patients either denying constipation or complaining of diarrhœa. Inspection of the motions will usually disclose the actual state of affairs, as the fæces will be found to be hard and fragmentary, finely cylindrical, or but loosely attached to each other. Diarrhœal interludes are usually stormy in their onset, the patient being suddenly seized with an urgent desire to go to stool, the attack being accompanied by great distress, cold sweating, pallor, and chilliness of the extremities. Naturally, abdominal pain is considerable at such times, but even without diarrhœa these patients suffer much from irregular colicky pains, sometimes continuous, at others paroxysmal, always depressing and wearying. Sooner or later the mucous discharge appears, generally in association with the stools, but occasionally by itself or accompanied only by flatus. In appearance it varies from a liquid, more or less stained with fæcal colouring matter, to a solid that assumes the character of false membrane. The solid mucus thus passed may be either stringy, or in flat bands like ribbon, or cylindrical, in which last case it takes the form of a cast of the intestine. When the condition is once established many secondary symptoms ensue, most of them being associated with functional disturbances of various organs. Thus, neurasthenia and hysteria, vasomotor phenomena, gastric derangements, dysmenorrhœa, leucorrhœa, lithæmia, urticaria, and eczema are met with, and the general health is invariably affected adversely in ways pointing to disturbances of nutrition. It is noticeable that intestinal sand is frequently associated with mucomembranous enterocolitis, the sand being either grey in colour or brick-red. This sand has never been found to contain uric acid, but in composition closely resembles the fine calculi that form in glands, such as the lachrymal and salivary. Dr. Froussard is of opinion that appendicitis is a complication of mucomembranous enterocolitis; the sudden form of appendicitis is rare, but it not infrequently happens that the cæcum and appendix share in the general disturbance of the lower bowel in colitis, and that the appendix is thus rendered a prey to the indigenous bacteria, with resulting subacute attacks of appendicitis. Although the ultimate prognosis of mucomembranous enterocolitis, unless accompanied by hæmorrhage and marked general wasting, is good, the disease is a chronic one, and demands prolonged and energetic treatment if the symptoms are to be relieved and the general health preserved. A quiet, well-ordered life, free from bustle and excitement, is essential, and the diet needs careful regulation. As a rule, meat, fish, green vegetables and fats are injurious, or only permissible in small quantities and when well-cooked, but starchy foods, with the addition of milk and butter and eggs, are well borne. It seems that the general indications are best met by residence at a mountain spa, where complete rest and fresh air in abundance are to be obtained. Among drugs, castor oil is the most valuable, but magnesium sulphate acts well in relieving the constipation, whilst opium, belladonna, hyoscyamus, and chloral may all be needed to meet special symptoms. Hydrotherapy, skilled massage, and electricity all have their place, but the most useful all-round measure is irrigation of the colon. This is best carried out with hot water run in at low pressure, and should be performed systematically, unless contra-indicated by pain. The cure is generally a tedious and protracted one, but the disease causes so much suffering that the trouble is well repaid if persistently carried out.

Notes on Current Topics.

Bacteriology for Pharmaceutical Chemists.

Some months ago a correspondence took place in the columns of the pharmaceutical journals regarding the advisability of pharmacists adopting clinical bacteriology as a "side-line" in their business. The proposal has now taken definite shape in the form of a notice of motion before the Council of the Pharmaceutical Society to the effect that the Education Committee of the Society should take into consideration the question of giving systematic instruction and conducting examinations in clinical bacteriology and clinical chemistry. We have very great sympathy with the Pharmaceutical Society in its endeavours to maintain the status and dignity of the craft of pharmacy, and we trust it will not be misled by this suggestion into undertaking responsibilities beyond its sphere. Let the shoemaker stick to his last, as much in his own interest as in that of the community. Anyone who knows anything of clinical bacteriology or chemistry knows that it is a branch of scientific work which requires as serious training, as much skill, and as extensive experience for its successful practice as, let us, say, operative surgery or any other work that falls to the specialist in any line of medical activity. Clinical bacteriolgy, to be of any value, requires in its practitioners not merely special training in laboratory method, which of itself would be useless, but a wide scientific training, and an extensive clinical knowledge. The pharmaceutical chemist cannot, without devoting many years to special training, acquire a knowledge of clinical bacteriology of any service to the physician. It is, we suppose, the business success of the chemist in so-called "counter-prescribing," which has led him to suggest this extension of his activities in the sphere of medical practice. In both cases such unqualified practice is fraught with danger to the public.

Wistar Institute.

The city of Philadelphia and the whole of the States of America generally have benefited by the will of the late General Isaac D. Wistar, for this enlightened gentleman made the Wistar Institute of Anatomy and Biology the residuary legatee of his large estate. The Institute was founded in 1892, and formally opened two years later as a place for research and study in the sciences mentioned. The nucleus of an anatomical museum was provided by the transfer to the Institute of the collection of anatomical objects made by Dr. Caspar Wistar, Professor of Anatomy in the University of Pennsylvania, in the early part of last century, and an endowment providing 3,000 dollars a year, which was gradually increased till it produced 40,000 dollars, was provided during the lifetime of General Wistar. A handsome and convenient building was erected by the same philanthropist, and this, too, has been gradually enlarged, till now Philadelphia may claim to have what is probably the finest private institution for the study of anatomy that exists anywhere in the world. A meeting of American anatomists was recently held to decide in what way the Institute might be worked to the greatest advantage, and it was decided that the study of neurology by a combined staff should be undertaken in the first place and that comparative anatomy and embryology should be regarded as ranking next in order of importance for purposes of investigation. The Institute has now been organised on business-like lines, and the committee of management hope to be able to deal in a liberal spirit with all applications for research from wherever received. The Americans are realising in a way that this country but faintly grasps, that the surest way to sound progress is through the study of pure science, and the fact of the Wistar Institute being in no way directly utilitarian is a standing testimony to the spiritual appreciation by our cousins of a truth which the practical Britisher has not the faculty of perceiving.

Opium in the Transvaal.

ONE of the unforeseen, though sufficiently obvious, consequences of the importation of Chinese labour to the Transvaal has been a largely increased consumption of opium. Everyone who knows China is aware that the consumption of opium is to the Chinaman very much what the consumption of beer is to his English brother. However harmful or comforting, according to the point of view, the drug may be in each case, it must from the practical standpoint be regarded as a necessary fact in each case, and one would think that a far-seeing statesman could have seen so far as to deal with it in that light. As a matter of fact, the Chinaman in the mines, in defiance of Transvaal poison laws, smoked his pipe of peace with the equanimity which distinguishes him in good and bad fortune. An outcry has now arisen as to the flagrant breach of the laws, and the Transvaal Government has promulgated very stringent regulations regarding the importation of opium. In future no one is to introduce opium in any form to the Colony except he be a registered medical practitioner, dentist, chemist, or druggist acting by permit of the Colonial Secretary; breach of this ordinance is punishable by a fine of five hundred pounds, or six months' imprisonment. Anyone having in his possession opium for other than medicinal purposes renders himself liable to a similar penalty. It remains to be seen whether these well-intentioned efforts will be successful.

Mammary Syphilis.

GUMMATA of the breast must be very rare in their occurrence, for but few cases are to be found recorded in medical literature, and it must be still more rare to find a case of mammary syphilis in which the condition produced simulates malignant disease. A patient with such appearances was brought to Dr. Edwin Beer, of New York, and he has recorded his clinical findings in the *Medical News* for October 28th. The woman in question was thirty-five years old, and except for slight anæmia was in fair general health. Four months previously she had noticed lumps forming in the left breast and axilla, and these had gone on growing in size. She consulted a medical man, and was advised that she had cancer and should have the breast removed. When seen by Dr. Beer, a soft, indistinctly-outlined, freely-movable mass, two inches by three, was found in the upper half of the breast; a similar but smaller mass lay below the middle of the clavicle, and covered by the pectoralis major; other masses in the axilla and super-clavicular region; and many enlarged lymph-glands in the axilla and posterior triangle of the neck. These glands were of normal consistency. Dr. Beer resisted the temptation to diagnose malignant disease, seeing that the masses and the lymph-glands were all softer than would be expected in cancer, and he formed a provisional diagnosis of syphilis. After some difficulty an undoubted history of secondary syphilis was obtained from the woman, who also stated that she still suffered from sore throat and pains in the bones. The patient was given mercury hypodermically, and iodides by the mouth, the latter in large and increasing doses. After one month Dr. Beer found the breast normal, the lump in the axilla and that above the clavicle gone; the lump below the clavicle half its previous size; the lymph-glands smaller, and the patient much improved generally. After another month's treatment practically nothing abnormal could be found except some thickening below the clavicle. a few enlarged lymph-glands in the opposite axilla. The diagnosis of the case, therefore, was abundantly confirmed.

"Graft."

SOME very curious evidence was given in a case heard recently before Judge Selfe, which seems to show that the American system of "graft" is finding its way into this country. The action was taken by a medical man to recover fees from a lady patient for professional attendance. One of the items charged in the bill was a sum of two guineas for a nurse's attendance. There was no suggestion that the charge was excessive, but the plaintiff admitted in cross-examination that of the two guineas he charged the defendant for the nurse's attendance, one was kept by himself. He added the extraordinary information. "It is a usual thing for a doctor to pocket half the nurses' fees in this way." If this be so, it is news to us, and we can only say that it is a highly improper practice. It is inadvisable in any case for a doctor to act as intermediary between patient and nurse in the matter of payment, but we can think of no possible excuse for charging the patient double the amount paid to the nurse. The transaction seems to us on a par with what is, we understand, a not uncommon practice in the States, where a consulting surgeon charges an excessive fee to a patient, the excess being regarded as a *douceur* to the patient's own medical attendant.

Knighthood for the President of the Royal College of Surgeons in Ireland.

We have sincere pleasure in congratulating the President of the Royal College of Surgeons in Ireland on the well-deserved distinction which has been conferred upon him by His Majesty in including his name in the list of Birthday Honours amongst those on whom a Knighthood is to be conferred. Mr. Chance is well known both in medical and lay circles in Dublin. Besides being President of the Royal College of Surgeons in Ireland, he is surgeon to the Mater Misericordiæ Hospital, the Dublin Orthopædic Hospital, and consulting surgeon to the St. Michael's Hospital. He is also President of the Surgical Section of the Royal Academy of Medicine of Ireland, and was formerly Surgeon-in-Ordinary to the Lord Lieutenant. Mr. Chance has always taken a keen interest in medical politics and in medical education in Ireland, and though his views on the latter subject may be regarded by some as of a revolutionary tendency, the intimate knowledge which he exhibits of the subject always ensures their careful consideration. He has always been a strenuous supporter of reform in the Poor-law Service, and only a couple of weeks ago we reported the excellent advice which he gave to potential candidates at the opening of the Session in his College school. We are sure that the honour he has received will be a popular one, and that it will reflect credit on the medical profession.

Medical Papers and Proprietary Medicines.

Our contemporary the *Journal of the American Medical Association* is not having by any means an easy task in its attempt to enlighten the physicians of the States on various points regarding the trade in proprietary articles. Many of the proprietors of much-advertised preparations regard the undertaking as a direct attack on their trade, and they are ready to use any weapon in self-defence. In particular, many of the less important medical papers, whose existence depends in great part on the returns from their advertisement columns, have published violent attacks on the *Journal* and on the personality of its editor. In some cases these attacks are little else than paraphrases of the matter to be found in the advertising columns of the same papers. How strong a hold some of these manufacturing druggists have over the medical press in America is shown in an amusing way by a letter to the *Journal* itself from the proprietors of a much-vaunted hæmatinic, many of whose advertisements are doubtless at present in our readers' waste-paper baskets. In an editorial article in our contemporary some months ago, the statement occurred that "the day of blind reliance on iron, quinine, and tonics in general in the treatment of anæmic conditions in tropical countries is past, never to return." This seemingly innocent remark drew forth an indignant letter of remonstrance from the proprietors of the hæmatinic who regard it as a direct "slap in the face," since it is alleged to cast a slight on their preparation, and they threaten in consequence to withdraw their advertisement. When an attempt is made to restrain such a paper as the *Journal of the American Medical Association* from free comment, one may judge the freedom permitted to less independent and less scrupulous journals.

The Forthcoming Vacancy at the Fever Hospital, Dublin.

In our issue of February 11th, 1903, we directed attention to the manner in which hospital appointments should and should not be made, and expressed the opinion that the method of making them at Cork Street Fever Hospital, Dublin, did not always conduce to obtaining the best possible selection. We are perfectly sure that no idea of making a more or less hole-and-corner appointment presented itself either to the Governors or to those responsible for the execution of the Governors' orders. The fact, however, remains that on the occasion of the last election, the vacancy was announced, as we are informed, in the columns of the *General Advertiser* alone—a paper not as a rule studied by medical men; that in this journal it appeared only once; and that, as a result, only two candidates presented themselves. We are further informed that the election took place long before the actual vacancy occurred, and that even members of the visiting medical staff were not aware that it was to take place. Such a method is obviously an improper one, and is capable of drawing down on the hospital authorities much undeserved censure. We make these remarks in view of the fact that a vacancy in the ranks of the visiting physicians will occur in March next. We understand that directions have been issued that the vacancy shall be advertised in December, and that the election will be held in January. This being so, and as the post in question is one of considerable professional value as well as being of a remunerative character, we think that an opportunity should be given to any medical man who may desire to present himself as a candidate, and this can only be done by giving full and timely notice.

Diet and Children's Teeth.

It has often been pointed out that between the mouth of the civilised man and that of the savage there is, as regards the state of health of the teeth, a marked contrast in favour of the latter. It must not be supposed, indeed, that the teeth of the primitive man never suffer from caries, since even in prehistoric skulls carious teeth have been found, but on the whole the primitive man suffers much less than his cultured brother. This difference is most easily explained by difference in diet, and in general terms it may be stated that the more mastication teeth have to perform the sounder their condition. This fact may be applied with advantage to the case of children. There is, at the present day, far too much disinclination to give children proper exercise for their jaws. As soon as a child gets teeth, he should be given something which requires their service. The constant feeding of a child two or three years old with sloppy foods practically liquid or pultaceous in character, is not only injurious to his teeth but to his organs of digestion in general. Mastication of fairly tough substances is the best way of keeping the teeth in a clean condition, while on the other hand when decomposing matter begins to collect round the teeth it is practically impossible to guard against caries. It is probably just as injurious to the child to be over-careful in the choice of food thought to be easily digestible as to treat him on the more rough-and-ready plan of our ancestors. A child has teeth and digestive organs, and he should be given such food as will call out the functions of both.

Lodging-Houses and Fire-Risks.

Of late years, public attention has been drawn to various fatal fires in different parts of the Kingdom, where the loss of human life has been due to want of proper exits. In the City of London a few years ago, on one memorable occasion, a number of girls were burnt alive because their only possible exit was through a doorway cut off by a floor filled with flames and dense smoke. Similar death-traps have been since unearthed in London by the agency of the Coroner's Court. They exist, however, throughout the United Kingdom, and the legislative need for efficient control of all structures, whether domestic, official or industrial, is universal. Acts of Parliament are defective, as they are not retrospective, so that old buildings, which from the nature of the case are often the worst in construction, escape the regulation. Another absurdity is that which does not enforce control of workshops unless a certain fixed number of workers are employed, so that many dangerous occupations are carried on in top floors of city buildings. Some common lodging-houses are nothing more than veritable death-traps in case of fire. It is reassuring to find that the London County Council recognise that their duty does not begin and end in seeing that there is a proper allowance of cubic space and a due use of the whitewash brush in such places. They are now refusing to license lodging-houses on the score of fire risks. Recently they have refused their further sanction to some timber buildings two hundred years old, which housed 118 women and 104 men. The place, it was reported, was "full of little rooms and dark corners, and if a fire occurred something too terrible would happen, everything being as dry as tinder." It would be well for medical officers of health to note structural deficiencies of this kind in the inspection of premises generally.

The "Sixpenny" Doctor.

We would that a story told in the Greenwich County Court last week might find its way to the desks of gentlemen who are preparing introductory addresses and heroics on medical progress. The defendant to a claim for debt was a doctor in practice in the neighbourhood, and he simply pleaded inability to pay. He explained to the judge that so many "sixpenny" doctors had opened dispensaries around him that his practice had seriously fallen off, and that he found it impossible to make a living. That the plea was a genuine one was shown by the judge refusing to make an order for payment, and the poor debtor was at least spared the additional embarrassment of having to find the money he so sorely needed for his own sustenance. As a commentary on the state of medical practice in many of the poorer districts, we think this simple, unvarnished story would be hard to beat. It needs no adornment. The mind can easily picture what must be the state of the finances of the crowd of "sixpenny" doctors themselves who are thus struggling for a livelihood, and what sort of a livelihood it must be that they earn. Is it possible to reconcile with the idea of that dignity which is supposed to be of the essence of the practice of medicine, the existence in London of a number of doctors cutting prices till one at least is unable to pay his debts? And sixpenny fees? How coldly ironical it seems to turn from them to hear of the benevolence that medical men should show to the poor when they are sick!

The Local Government Board Speaks Out.

The general efficiency of public health administration of the United Kingdom is closely connected with the energy displayed by the Local Government Board. There can be no doubt that on the whole that central body has achieved and is still achieving a vast deal of vital progress. At the same time its lack of initiative has often been pointed out in these columns. Its medical inspectors have often permitted year after year the continuance of poor-law abuses of a flagrant kind, the existence of which has been brought to public notice by some chance occurrence. Then, again, the Local Government Board now and then fails to enforce the proper carrying out of the Vaccination Acts and to protect vaccination officers. Often, too, has the medical officer of health to complain of the failure of the Board in time of stress, when he is hindered or prevented by his sanitary authority from carrying out his plain bounden duty. But the recent policy of the Board in the case of the medical officer of Welsbourne, Stratford-on-Avon, merits nothing save praise. On appointing a new officer the Guardians cut down, by the sum of £10. the magnificent salary of £50 attached to the post. The action of the L.G.B. in objecting to this is stigmatised by the *Morning Leader* of November 8th as "a piece of impudence." That journal appears to think that the ratepayers are to be saddled with an unnecessary expenditure of £10 per annum simply to gratify a whim of the Local Government Board. As a matter of fact, the miserable inadequacy of the salary of many rural medical officerships is proof of the policy whereby those indispensable servants of the public are kept under the thumb of local authorities. As a consequence, the sanitary condition of not a few rural districts is a blot upon our modern civilisation. It is to be hoped that the Local Government Board, having put its hand to the plough, will end by insisting that the work is properly completed by granting adequate salaries to medical officers.

Reinstated Volunteers.

It fell to our lot a few months ago to speak of the great dissatisfaction which was felt by the profession at the way in which a medical examination was forced on the volunteers by the Secretary for War. We pointed out at that time that though the health of the armed forces was a matter of the highest importance to the country, and their physique not less so, the method taken by Mr. Arnold-Forster for finding out how many volunteers were fit for foreign service was illegal, and that to press such an examination was not only galling to the men but calculated to bring medical examination and medical officers into undeserved unpopularity. However, the examination was forced on the men by their officers in spite of Mr. Arnold-Forster's statement that it was voluntary, and several non-commissioned officers—some with high records of service—were dismissed from the force because of their refusal to submit. Such refusals constituted the most potent evidence of the unpopularity of the step, and were sincerely to be deplored in the interests of fair play and discipline. It is, therefore, with great satisfaction that we see that the War Office has had the courage—at the eleventh hour, it is true—to admit that an error was made, and that the dismissed N.C.O.'s were unjustly treated. It has been decided that they are to be reinstated immediately, and we are sure that the news will be received with pleasure by the civil population, who are so deeply interested in the maintenance of the volunteer force. We present our congratulations to the non-commissioned officers on their reinstatement, and to Mr. Arnold-Forster for the tacit admission of his error.

What is Whisky?

For some years past one has been accustomed to prosecutions of publicans for having purveyed a mixture of brandy and "silent" spirit under the name of "brandy," and happily there have now been so many decisions as to what constitutes "brandy" that there is but little difficulty in most parts of the country in getting convictions in the case of those who sell adulterated spirits as the real article. Much of the evidence against "silent" spirit adulteration has been directed to showing that brandy which is deprived of the right proportion of its ethers is inferior, for medicinal purposes, to genuine grape-brandy. Largely, perhaps, through tradition or fashion, brandy is still the spirit most widely prescribed in illness, and whisky has been left to the healthy for their gastronomic delectation. Now it would seem, from a prosecution that took place at the North London Police Court last week, that the definition of what "whisky" is, is as hazy as that of what brandy was till recently. The Islington Borough Council have taken out a number of summonses against spirit dealers in their district for selling as "whisky" the product of the patent still—that is, "silent" spirit—instead of that of the old pot-still. It is alleged by the prosecution that by the use of the patent still the "impurities" which give its character to whisky are eliminated, and therefore such spirit cannot be regarded as "whisky," and that the manufacturers of these brands use the patent instead of the pot-still because the spirit from the former could be produced at a third the price of the latter. Although this practice would seem to be common as regards the cheaper "whiskies," it is reassuring to have the evidence of Dr. Teed, the analyst called by the prosecution, that many of the well-known brands contain the genuine spirit. The decision of the magistrate will be an important one, as, if adverse to the patent still product, it is likely to be followed by a crop of prosecutions all over the country.

The Coffee Habit.

A medical practitioner who claims to "make a speciality of dietetics" has permitted certain statements to appear in the public Press concerning the alleged "coffee" intemperance in this country. It is certainly a fact that there is a "wave of temperance" passing over the public as regards alcoholic beverages. When this billow has rolled by there will be doubtless minor wavelets in its wake. Already there are signs of a reaction, and, since human nature is always the same, if the days of alcohol are over it will be replaced by a score of so-called harmless beverages. We are by no means prepared to admit that tea and coffee are abused to the same degree as alcohol, Excessive tea-drinking is sometimes met with.

especially among women, but it must be remembered that good tea is cheaper and easier to make than good coffee. As a "pick-me-up" coffee is far more valuable than tea, its stimulating effect upon the cerebral cortex being well marked, and as it contains a relatively small proportion of tannin it does not so often cause indigestion. The habit of taking coffee after dinner is not viciously unscientific. Caffeine does not interfere with the digestive processes; indeed, by slightly accelerating the heart's action, it directly assists the stomach in performing its functions. The influence of personal idiosyncrasy is sometimes strangely manifest when comparing the effects of coffee taken late at night upon different individuals. It acts like a hot bath in sending one man to sleep and keeping another wide awake. Some cases of habitual insomnia can be undoubtedly traced to the habit of taking strong coffee shortly before going to bed. But in this, as in many other things, each individual is a law unto himself. He must find out his own little nervous ways and act accordingly. Tea, coffee, tobacco, and other nerve stimulants are good servants but bad masters.

Stealing Door-Plates.

In a bygone generation the wrenching of door-knockers formed an inexhaustible source of amusement. Prowess in that curious pastime was not infrequently testified to by the collection of knockers and bell-pulls that graced the wigwam of the "buck" or "dandy" of Georgian times. Nowadays, that tortuous path of pleasure has become deserted. A glimpse of a spurious and feeble imitation, however, came before a London police court the other day, when a man was convicted of stealing a number of doctors' brass name-plates, thirty or forty of which had disappeared from a suburb in the West of London. The value of the metal of the plates can be only a few pence, so that it is to be anticipated that this eccentric larceny will not come into widespread popularity among thieves.

PERSONAL.

Professor W. R. Smith has been elected Mayor of Holborn.

Mr. C. B. Lockwood, F.R.C.S., President of the Harveian Society of London, will take the chair at the annual dinner, on Thursday, November 23rd, to be held at the Wharncliffe Rooms, Hotel Great Central.

Sir Frederick Treves, Bart., K.C.V.O., C.B., was on Saturday elected Lord Rector of Aberdeen University, by 390 votes against 153 given for Mr. C. T. Ritchie, M.P., who has been Lord Rector for the last three years.

Amongst the names included in the list of "Birthday Honours" are to be found those of Mr. Arthur Chance, President of the Royal College of Surgeons in Ireland; Dr. James Barr, physician to the Royal Infirmary, Liverpool; Dr. Theodore Thomson, Medical Inspector of the Local Government Board; Dr. Armand Ruffer, President of the Egyptian Sanitary Board; Mr. John McFadyean, Royal Veterinary College, London; Dr. Featherston Cargill, First Class Resident in the Protectorate of Northern Nigeria; and Sir Felix Semon, C.V.O., Physician Extraordinary to his Majesty.

Sir John W. Moore, M.D., will read a paper on "The Rainstorm of August 24th and 26th, 1905, in Co. Dublin and Co. Wicklow," at the meeting of the Royal Meteorological Society to be held at the Institution of Civil Engineers, Great George Street, Westminster, this evening at 7.30 p.m.

Dr. Cullingworth has been appointed Editor-in-Chief of the *Journal of Obstetrics and Gynæcology of the British Empire*. He will have the assistance of a large editorial staff, amongst whom the present Master of the Rotunda Hospital, Dr. Hastings Tweedy, will be responsible for Ireland.

The late Dr. William Fuller, of Oswestry, who died in August last, at the age of 88, left estate of the net value of £41,257.

Mr. Henry T. Butlin will deliver the Bradshaw Lecture at the Royal College of Surgeons of England on Wednesday, Dec. 13th, at 5 o'clock p.m. The subject of the lecture will be "Carcinoma is a Parasitic Disease."

Surgeon G. Gibson, R.N., of the *Assistance*, has been awarded a bronze medal by the committee of the Royal Humane Society for his gallantry in jumping overboard from that vessel on August 18th and saving a seaman.

In accordance with the provisions of her late Majesty's Order in Council, Fleet-Surgeon Archibald McKinlay has been placed on the Retired List, of the Royal Navy Medical Service, at his own request, with permission to assume the rank of Deputy Inspector-General of Hospitals and Fleets.

Dr. Leslie Milburn, D.P.H., has been unanimously appointed Medical Officer of Health to the important Borough of Tynemouth.

Dr. G. Watson has resigned the post of Assistant to the Director of the Pathological Laboratories of the London County Asylums, having been appointed to succeed Dr. Campbell as Pathologist to Rainhill Asylum.

We understand that the names of two members of the medical profession are on the list for election to the Council of the Royal Society on the 30th inst., viz., Sir Lauder Brunton and Professor Ernest Stanley, M.D.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

SCOTLAND.

Aberdeen University Rectorial Election.—Polling took place on November 11th, and resulted in the victory of Sir Frederick Treves over Mr. Ritchie in all the Nations by a grand total of 237 votes. The exact figures are:—Moray Nation—Treves 63, Ritchie 25; Mar Nation—Treves 113, Ritchie 46; Buchan Nation—Treves 121, Ritchie 55; Angus Nation—Treves 93, Ritchie 27; total—Treves 390, Ritchie 153. On receiving news of his success, Sir Frederick telegraphed as follows:—"I am very proud of the great honour the students of the famous University of Aberdeen have conferred upon me in electing me Lord Rector. I sincerely appreciate the very high distinction, and only wish I could thank my generous supporters in person. Many thanks for your kind congratulations."

Edinburgh University.—Election of Assessors of the General Council to the University Court.—Edinburgh graduates all over the country may have experienced some little surprise and wonder at receiving voting papers and addresses from three candidates for the post of assessors to the University Court, for it is a great number of years since a contest has occurred. As it is only through these assessors that the general body of graduates can exert any influence on the government of the University it is by no means a bad thing that the fact that they have certain powers should from time to time be brought home to graduates, and it is to be hoped that those who still retain an interest in their *alma mater* will read the addresses of the candidates, and not too hastily consign the whole to the wastepaper basket. Of the four assessors which the General Council sends, two are by general consent representatives of the medical profession, and they (Drs. Joseph Bell and Mackenzie Johnston) do not at present come up for re-election, as do Mr. Lorimer and Mr. Lowe. At the statutory half-yearly meeting of the Council, at which the election of assessors is usually carried through by voting by show of hands, Mr. Lorimer and Mr. Lowe were proposed for re-election, and Mr. Traill came forward as a new entrant to the field. On a vote being taken, Mr. Balfour, who, as Chancellor of the University, presided, decided that Messrs. Lowe and Traill had most votes, whereupon Mr. Lorimer's supporters asked for a poll. The views of the different candidates are sufficiently clearly set forth in the addresses issued to the members of the General Council, but we venture to appeal to medical men to support Mr. Lorimer. He has devoted much time and energy to carrying through certain reforms in the time-table of the medical curriculum, and his rejection would be a serious, if not fatal, blow to the prospects of a scheme which if carried out will do a great deal to spare the medical student's time, and enable him to arrange his classes more profitably. One of the fundamental principles of the re-modelled curriculum is the division of the year into three instead of two sessions, and it can well be conceived that so drastic a change involves an enormous amount of adjustment in detail. Mr. Lorimer has the requisite knowledge and experience to enable him to understand the intricacies of the matter, and for this reason, as well as because he has the success of the proposed change at heart, his candidature ought to receive the support of the medical profession.

ULSTER MEDICAL SOCIETY.

The first meeting of the session was held in the Medical Institute, College Square, Belfast, on Thursday evening, November 9th. The president, Dr. William Calwell, delivered an inaugural address, taking for his subject some observations on the

CLASSIFICATION AND TREATMENT OF AFFECTIONS OF THE STOMACH.

Before entering on the discussion of his subject, he congratulated three Fellows of the Society on the honours lately conferred on them—Sir William Whitla on his honorary degree at Edinburgh University, Dr. Graham on his appointment as His Majesty's Coroner for the City of Belfast, and Dr. Henry O'Neill on his appointment as High Sheriff for the City. He also referred to Sir Donald Currie's generous offer to Queen's College, and to the deaths of three members, Drs. Owen Praeger, John McClatchy, and George F. Wales, the last one of the oldest members of the Society, and the others among the youngest.

Dealing with the special subject he had chosen for his address, Dr. Calwell said that he would devote his time to the consideration of questions of treatment, making only a few preliminary observations on classification, and the treatment he wished to dwell on chiefly was that of ulcer and dilatation. He considered first catarrhal gastritis, and the confusion frequently arising from its occurring as a complication of other affections. Operation should not be thought of. Dealing with gastric ulcer, he said that he believed both the formation and healing of ulcers of the stomach might be much more rapid than generally accepted. The first point in treatment was rest in bed, continued till all trace of pain and tenderness were gone, and normal diet could be taken. When nutrient enemata were to be used, he advised a soft rubber male catheter attached to a glass funnel, the end to be passed not more than two inches in, and about ten ounces of fluid administered. The food he preferred to give in this way was fresh milk freshly peptonised, and rather more peptonised than for use by the mouth. It was generally unwise to use enemata for more than five days, especially if there had been any loss of blood. If there were any sign of sinking he stopped the enemata at once and returned to mouth feeding. As soon as two pints of milk were taken in the day by the mouth the use of the enema should be stopped; it sometimes caused vomiting, which ceased as soon as its use was ceased. When three pints were taken in the day he changed by degrees to fresh milk, and then added other forms of food. Drugs were better avoided in most cases.

The complications which might have to be treated were gastric catarrh and hæmatemesis. With the former rest and absence of food were generally sufficient. A little magnesia, soda, and menthol in warm water might be sipped occasionally. Hæmatemesis might conveniently be considered according to its degree of severity. In slight cases, where there were only one or two small hæmorrhages, the patient should rest in bed and take nothing by the mouth but a little water for twenty-four hours. Ice should not be used, as it did more harm than good. If there were no further hæmorrhage, a little warm milk and water might be given the next day. In more severe cases nutrient enemata should be used for three to five days, and nothing given by the mouth but an occasional teaspoonful of water. Perfect quiet should, of course, be enjoined. Chloride of calcium might be given by the bowel. If there were much restlessness a small hypodermic of morphia might be given, but other drugs did more harm than good.

As regards the question of the distension of the stomach by flatulence as a cause of bleeding, Dr. Calwell was inclined to agree that it might be so, and thought that in some cases it was right to take active measures to relieve it. If saline infusion were needed it was better to do it early rather than late. The question of operation in these cases was very difficult to decide, but on the whole his opinion was against it.

Acute ulcer heals in 90 per cent. of the cases if it gets a chance; if not, it is liable to drift into chronic. Rest and careful feeding should be tried for a month before resorting to operation.

Dealing with dilatation of the stomach, Dr. Calwell said that the acute was so rare that he would confine his remarks to the chronic form, occurring either with or without organic structure. In the first-class rest in bed generally gives great relief, and with proper feeding and lavage seemed to effect a cure, and probably in some cases actually did so. If, however, this was not the case, and the only outlook for the patient was a life of chronic invalidism, the sooner gastro-jejunostomy was done the better.

In cases where no stricture was present the nervous element was most important, and indeed might be the real cause, for we were as yet in the position of not being able to say which was the cart and which was the horse. At the conclusion of the address, a vote of thanks to Dr. Calwell was moved by Dr. Henry O'Neill seconded by Dr. St. George, and passed by acclamation.

The report of the Council, read by the Hon. Secretary, Dr. Houston, stated that the Council had resolved that the annual dinner should this year be a private function, no official guests being asked, and the toast list reduced to the smallest dimensions. Tea and coffee were provided by the President after the meeting.

Central Midwives Board.

During the October meetings of the Central Midwives Board there were four hundred and sixty-three candidates examined, of whom three hundred and fifty-two passed and one hundred and eleven failed. The percentage of failures, therefore, was twenty-four,

Correspondence.

THE WATER SUPPLY OF LONDON.

To the Editor of The Medical Press and Circular.

Sir,—The article on "How to Sterilise Drinking Water and other Fluids," by David Walsh, M.D., published in The Medical Press and Circular for November 1st, is extremely valuable and instructive. While other cities are securing a pure and efficient supply of water, no adequate reform of the kind has been taken in hand in the interests of the inhabitants of London. Quite recently Liverpool has inaugurated its second pipe line, furnishing an additional supply of fifteen millions of gallons of pure water at a cost of £700,000. And only a few weeks since the press called attention to what the municipal authorities of Edinburgh and Leith have accomplished by the opening of a new supply, which had been in course of construction for ten years, and furnishes twenty-five millions of gallons daily at an outlay of £1,250,000. The *Lancet* has pointed out that all the water areas are being gradually acquired by provincial towns, and any further delay in following their example is perilous to the health of the vast population of the Metropolis, which depends mainly upon the Thames for its domestic water supply. The London Water Board appears to be tinkering with comparatively unimportant details, and ignoring the fact that five Commissions, after exhaustive inquiry, have condemned the present water supply as incurably contaminated. The upper reaches of the river Dee, where the surplus water is now wasted by floods, would, it is believed, provide an ample source of excellent water for all practical purposes. On page 26 of Dr. W. Scott Tebb's recently-published pamphlet on the "Metropolitan Water Supply," is the following :—"In the report for 1876, Sir Edward Frankland writes, 'When the heavy rains of December set in, the accumulated filth of the summer and autumn was swept into the neighbouring streams, the Thames overflowed its banks, washing the manure from cultivated land, and liberating the water from the stagnant ponds and ditches. Thus during the last month of the year the Thames was laden with organic matters of the most objectionable origin, which, carried down to the intakes of the Metropolitan Water Companies, passed through the filters and were distributed to customers. Since January, 1873, the Thames has never been in such a filthy plight.' In referring to filtration, he says, 'No care, foresight, or appliance could convert the *puddle* (to quote an entry in the books of the West Middlesex Company) which entered the Company's works into wholesome potable water fit for dietetic purposes. These uncontrollable and frequently-occurring outbreaks render this river a very undesirable source of water for domestic use.'" Successive reports of Sir Edward Frankland reveal similar sinister facts. In his summary of conclusions, Dr. Tebb says : "That the quality of the water as indicated by the analyses has shown no substantial improvement during the last thirty years." In the interests of public health, and for the avoidance of possible epidemics of zymotic disease, a new and pure supply of water for the Metropolis is imperative, and should not further be delayed. Thanking you for your kindness,

I am, Sir, yours truly,
Jas. R. Williamson.
100, Chedington Road, Upper Edmonton, N.
November 10th, 1905.

Obituary.

JOHN HAMMERTON EDWARDS, M.D., Cantab.

Mr. John Hammerton Edwards, M.D.Cantab., Honorary Associate of the Order of St. John of Jerusalem and lecturer and examiner of the St. John Ambulance Association, died at his residence, Bedford, at the age of forty-five. Dr. Edwards, who was educated at St. John's College, Cambridge, and at St. Bartholomew's Hospital, where he was Quested Exhibitioner and Shuter Scholar, graduated in 1881, proceeded to his M.A. degree in 1886, and took the M.D. degree in 1890. He was admitted a member of the Royal College of Surgeons and a licentiate of the Royal College of Physicians, London, in 1889.

JAMES JAMIESON, M.D., F.R.C.S.E., Edin.

We regret to record the death of Dr. Jamieson, at Edinburgh, on Friday, November 3rd, at the age of 64. He was educated at the Edinburgh Extramural School, and took the diplomas of L.R.C.P.E. and L.R.C.S.E., at the age of 23, and the Fellowship of the Royal College of Surgeons in 1880, and the degree of Doctor of Medicine of the University of St. Andrews in 1883. Dr. Jamieson was a member of the Edinburgh Borderers' Union, and one of the original members of the Council of the Border Counties Association. He was a well-known figure in medical circles, and took a deep interest in religious matters. He is survived by a widow and two sons, one of whom is a member of the medical and the other of the dental profession.

Medical News.

The Royal University of Ireland.—Adjourned Special Meeting of Standing Committee.

The Standing Committee met on Tuesday, November 7th, for the purpose of taking into consideration the behaviour of certain students at the recent ceremony of conferring of degrees.

The Vice-Chancellor, having expressed his regret for the absence of the Chancellor, said he would ask the Standing Committee, before they proceeded to the business for which they had been summoned, to allow him to make a short statement. He had put his views in writing, partly because he wished to be as brief as possible, and partly because he felt that in the grave crisis in which they were placed every word should be carefully weighed.

He then read a statement, which has already appeared in the daily press. In conclusion, the Vice-Chancellor said that in view of some letters which had appeared in the morning papers, it was right to say that his statement was written on the previous evening before he saw these letters, and that he had no knowledge whatever of any of the accused parties.

A discussion having taken place on the statement referred to, Mr. C. F. Doyle was called on to give his opinions as to the power of the Senate and Standing Committee. Mr. Doyle referred to the various sections of the Charter and Statutes dealing with the matter, and gave it as his opinion that under the Charter and Statutes of the University, the Senate was bound to examine every person presenting himself as a candidate and to confer degrees on such candidate if successful at his examinations, and has no power to inflict upon any person any punishment the infliction of which would be inconsistent with that duty. He was further of opinion that no power capable of being acquired by the promulgates of a Statute under Section 11 of the Charter can be put in force until such Statute is duty promulgated.

A resolution was then proposed that the question as to the powers of the Senate should be referred to the Law Officers of the Crown for their opinion. An amendment was moved that the Standing Committee should accept the decision of the Assessor and drop the proceedings. On a division, the amendment was lost and the resolution was carried. It was then further agreed to ask the Law Officers of the Crown whether, in case the Senate has not such powers, it could obtain power for the future by framing a Statute for the purpose under Section 11 of the Charter.

Royal College of Surgeons, England.

At a meeting of the Council, held on Thursday last, the President, Mr. John Tweedy, in the chair, a letter was read from Mr. W. H. A. Jacobson, resigning his membership of the Court of Examiners. The resignation was accepted, and will take effect on the conclusion of the next examination for the Fellowship. The president stated that the vacancy in the Court of Examiners thus occasioned would be filled up at the ordinary meeting of the Council in December. Regulations for the Begley Studentship, founded by the late Mrs. Jane Begley, widow of Dr. William Chapman Begley, a former member of the College, were adopted. The Studentship will consist of a sum of £20 per annum. It will be open to any candidate admitted to the second examination of the Conjoint Examining Board in England, held in April, 1906, and will be awarded to the candidate obtaining the highest number of marks in the anatomical part of the examination. The president stated that the Bradshaw Lecture would be delivered by Mr. Henry T. Butlin on Wednesday, December 13th, at 5 o'clock p.m., and that the subject of the lecture would be "Carcinoma is a Parasitic Disease." The secretary reminded the Council that the annual meeting of Fellows and Members would be held at the College on Thursday next, the 16th inst., at three o'clock p.m. The list of candidates who received the Diploma of Membership will be found under the heading of "Pass Lists."

Indian Medical Service.

Examinations for Commissions.—An examination for the selection of candidates for not less than twenty-one commissions in the Indian Medical Service will be held in London on January 23rd, 1906, and the four following days. Applications for admission to the examination must be sent in on or before January 9th, 1906. Copies of regulations for the examination, together with other information can be obtained on application to the Military Secretary, India Office, London, S.W.

The Royal University of Ireland Graduates Association.

The annual meeting of this Association was held in Belfast on November 3rd, the President, Dr. John Campbell, in the chair. After the President had delivered an address dealing with the subject of University Education in Ireland, and entitled "The Failure of Non-sectarian Education in Ireland, its Cause, and Remedy," the following motions were carried :—1. That we have observed with satisfaction the statement recently made by the Prime Minister that the demand for the establishment of a sectarian university is losing force, and that no Government in the present state of public opinion could introduce a Bill for that purpose; and accordingly, with renewed confidence, we reaffirm our determination to oppose the application of State funds, either directly or indirectly, to the support of a sectarian university or a sectarian college. 2. That the fact of the Royal University now possessing a body of 6,000 graduates justifies a demand that the present system of governing the University through a senate the preponderating majority of whom are appointed by the Crown for life—not as being qualified for the duties of the office, but as representing the churches to which they belong—should be altered; that the Crown nominations should be given to qualified men who will attend to their duties; that these nominations should not exceed one-third of the total number; and that the graduates, as being the persons most competent to direct university affairs, should elect the remaining two-thirds. 3. That we condemn in the strongest manner the abandonment of the Queen's Colleges of Cork and Galway recently proposed by Sir West Ridgeway. We consider that these Colleges, in view of the subsidised competition of the Jesuit College in Dublin, are under-endowed and, having regard to the increased requirements of modern education, we demand that the Colleges of Cork and Galway, as being the only sources of liberal and impartial culture which exist in the south and west of Ireland, should be generously supported. 4. That recognising the fact that the Queen's University and its colleges were secured as non-sectarian institutions through the efforts of a brilliant Roman Catholic layman, Sir Thomas Wyse, we have great satisfaction in observing a resuscitation of the spirit which animated him in his work; and, as university men who support non-sectarianism in secular education as in all secular affairs, we give our heartiest sympathy to those Roman Catholic laymen who are now working for the university reform on lines similar to those designed by that great Irishman, who was the far-seeing pioneer of non-sectarian constructive effort in all departments of secular education in Ireland.

Pass Lists.

Royal College of Surgeons of England.

The following candidates having passed the required examinations and conformed to the by laws, received their Diplomas of Membership at a meeting of the Council on November 9th :—Samuel F. Abbott, Richard J. Archibald, Hugh L. Askham, Wilfred G Attenborough, Edward B. Alyward, Alfred Ball, James L. Barford, Ernest C. E. Barnes, Alfred E. Baron, Jose Maria Barrionuevo, John D. Barrie, Henry Bazett, Frank G. Bergin, John H. Board, James R. Briscoe, John F. Broughton, Edward Bunting, Hugh W. Burman, Laurence H. Burner, Percy C. Bushnell, Maurice A. Cassidy, Henry J. Clarke, George Cockcroft, George H. U. Corbett, Vincent A. P. Costobadie, Walter Crampton, Frederick D. Crew, Ralph Crompton, John R. Davies, Haldinstein D. Davis, Harry L. Evans, Thomas J. C. Evans, Harold J. Fardon, Ebenezer R. Faulkner, Ethelbert R. Flint, Ralph A. Fuller, Ali Azhar H. Fyzee, Friedrich Gans, Stanley R. Gibbs, Lawrence G. Gibson, Robert T. Gilmour, Andrew S. S. Goonewardene, Hugh E. Gotelee, Harold O. Gough, Horace J. Gould, William B. Grandage, George F. Greening, Morris Grundy, Paul L. Guiseppi, Edward M. Harrison, William Harrison, Charles W. C. Harvey, Claude S. Harwood, Sydney A. Henry, Frederick S. Hewett, Leonard F. Hirst, Frederick D. G. Howell, Hector L. Howell, Alfred B. Howitt, Mark O. Hunter, Arthur H. Jacob, Alfred N. Jeans, Reginald C. Jewesbury, Valentine G. Johnson, Harry M. Langdale, Alan A. H. Lawrence, Arthur E. Leapingwell, Charles N. Le Brocq, George W. Lloyd, Walter G. Loughborough, George H. K. Macalister, Urban Marks, Evelyn Mayhew, Percy S. Mills, Ernleigh G. D. Milsom, Alfred W. Moore, Walter W. Moore, Arthur E. Oakeley, Evelyn H. B. Oran, Wilfred R. Pagen, Geoffrey O. Parsons, Vining G. J. Paul, Geoffrey R. Plaister, Leslie Rawes, Frederick J. Rees, Walter Reeve, Max B. Reichwald, Samuel S. Rendall, Percy W. Saunders, John E. Scales, Oswald L. Scarborough, John Walter L. Scott, Henry C. G. Semon, Douglas M. B. Snell, Herbert C. Squires, William D. Sturrock, Archibald A. Sutcliff, William S. Sweet, Philip Talbot, Claude E. Tangye, Martin B. Taylor, Robert S. Taylor, Arnold N. Thomas, John C. Teesdale, John E. L. A. Turnly, Oswald H. Vevers, William P. Walker, John Warburton, John G. Watkins, Charles S. Willis, Andrew John M. Wright, Alexander C. Wroughton.

Trinity College, Dublin.

At the Michaelmas Examinations, the following candidates passed in the subjects indicated :—

Anatomy and Institutes of Medicine.—John A. W. Ponton; George F. Graham; George Halpin; Edward J. H. Garstin; Gordon A. Jackson; Thomas P. S. Eves; Oliver St. J. Gogarty and Howard S. Millar (equal).

Physics and Chemistry.—George E. Craig; Duncan F. Hunter, Wm. H. M'Carthy, and Wm. Nicholson (equal); Thomas W. E. Henry; Edwin B. Bate, Robert E. Lee, and Wm. A. R. Spong (equal); Eric J. Powell; James E. M'Causland, Hugh S. Metcalfe, and William H. Hart (equal); Victor B. Kyle; Richard Charles, Alex. K. Cosgrave, Cecil P. Smyly, and James A. Yourell (equal).

Botany and Zoology.—Ralph Friel (Sch); Charles Hanan; George E. Craig; Peter H. Lemass; James Alston, Arthur C. Hallowes, and George B. M'Hutchinson (equal); Charles J. Pentland; Wm. H. M'Carthy,

Notices to Correspondents, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber" "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

DR. M.—Before taking any action regarding the patient's allegation our correspondent should first put himself in communication with the medical man concerned. We quite believe that it will be found that a different complexion will be placed upon the matter by those representing the other side of the case.

THE ANTISEPTIC BABY.

We can sterilize his bottles, we can boil his little mug
We can bake his flannel bandages and disinfect the rug
That envelops him when he partakes of medicated air,
But there s one impossibility that leaves us in despair—
And a not unjustifiable alarm, you will allow—
To wit: We fear 'twould never do to sterilise the cow!
Thus although we strive to conquer every septic circumstance,
Yet we greatly fear a ghastly alimentary mischance;
For albeit we bake and boil his things, and scrub and soak and souse—
As if in his anatomy forever cleaning house—
The recklessness with which he sucks his vagrant tiny thumb
Imperils much his precious antiseptic little tum.
We are careful of his hours, we are thoughtful of his toys;
We are mindful of his sorrows, and judicious of his joys
We are prayerfully considerate of needful discipline,
Of my little "Mother's Handbook" and the precepts writ therein
And we strive to render sterile all designed for mouth or tum,
But one frightful danger menaces—we cannot boil his thumb!
—"Harper's Magzaine"

SPES.—We should recommend Falmouth as a mild winter health resort. We think that nothing equals it in this country.

MRS. T. S.—Our correspondent would do well to place the matter of the recommendation of a specialist in the hands of her medical adviser.

HOUSE SURGEON.—It was perfectly correct and proper to withhold the certificate.

F.R.C.S.—No absolute rule obtains, but the course adopted by our correspondent was that which is customary.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 15th.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Exhibition of Microscope Slides of Tsetse-Fly Dissections, Trypanosomes, &c.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. M. White: Clinique. (Surgical.) 5.15 p.m. Mr. J. Pardoe: The Treatment of Chronic Urethritis.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W).—5 p.m. Dr. R. H. Cole Melancholia and its Treatment.

THURSDAY, NOVEMBER 16th.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret St., W.).—8 p.m. Lecture:—Prof. W. D. Halliburton: Physiological Child Life. (Arranged by the British Child-Study Association.)

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m. Dr. N. Moore: Dr. Edward Browne (1644-1708) and the Education of Physicians in London in the 17th Century. (Fitz-Patrick Lecture).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC, (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. T. W. Eden: The Treatment of Rupture of the Uterus by Abdominal Section.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Keetly: Hernia. (Lecture II.)

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Acne Vulgaris in its Three Stages—I., Comedo; II., Indurata; III., Necrotica. (Chesterfield Lecture.)

FRIDAY, NOVEMBER 17th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos St., Cavendish Square, W.).—5.30 p.m. Cases and Specimens will be shown by Dr. E. F. Buzzard, Dr. E. Cautley, Mr. G. Pernet, Mr. S. Stephenson, Mr. P. L. Mummery, and others. Short Communications:—Mr. R. C. Lucas: Calculus removed from the Ureter of a Boy aged 11 years.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.). 8.30 p.m. Paper: Dr. J. L. Todd: The Distribution and Spread of Sleeping Sickness in the Congo Free State, 1903-05.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. St. Clair Thompson: Clinique. (Throat.)

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road W.).—5 p.m. Mr. C. Williams: X-Rays—Diagnosis and Treatment (with lantern slides).

Vacancies.

Asylums Committee of the London County Council.—Assistant to the Pathologist of the London County Asylums. Salary £250 per annum. Applications to H. F. Keene, Clerk to the Asylums Committee, London Asylums Committee Office, 6 Waterloo Place, London, S.W.

Barra Parish Council.—Medical Officer. Salary £119 per annum. Applications to Thomas Wilson, Solicitor, Lochmaddy, Clerk.

Birmingham General Dispensary.—Resident Surgeon. Salary £150 per annum, and furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.

Brentford Union.—Assistant Medical Superintendent.—Salary £120 per annum, with furnished apartments in the Infirmary, rations, washing, etc. Applications to William Stephens, Clerk to the Guardians, Union Offices, Isleworth, W.

City of Nottingham Workhouse Infirmary.—Junior Resident Medical Officer. Salary £120 per annum, with apartments, board, washing, and attendance. Applications to G. Muncaster Howard, Clerk to the Board.

Dublin Incorporated Dental Hospital of Ireland:—Dentist to take charge of Prosthetic Department. Applications to the Registrar at the Hospital. (See Advt.)

Dublin Incorporated Dental Hospital of Ireland—Assistant House Surgeon. Application to the Registrar at the Hospital. (See Advt.)

Manchester Royal Infirmary and Dispensary.—Fourth Honorary Assistant Surgeon. Applications to the Secretary.

St. Bartholomew's Hospital, E.C.—Demonstrator in Physics. Salary £100 per annum. Applications to the Dean of the School.

Wilts County Asylum, Devizes.—Assistant Medical Officer. Salary £160 per annum, with board, residence, attendance, and washing Applications to the Medical Superintendent.

Wolverhampton and Staffordshire General Hospital.—House Governor and Secretary. Salary £200 per annum, with board, washing and residence in the Institution. Applications to the Chairman of the Board of Management.

Worksop Dispensary and Hospital.—Medical Officer, House Surgeon and Dispenser. Salary £150 per annum, with rooms, attendance, coal, and gas. Applications to the Secretary, 44 Bridge Street Worksop.

Appointments.

BARNES, ALFRED J., L.A.H., M.P.S.I., Examiner in Preliminary Education, Pharmaceutical Society of Ireland.

BATEMAN, W. HIRST, M.B., Ch.B.Vict., Honorary Medical Officer to the Rochdale Infirmary.

CLAY, JOHN, M.B., B.S.Durh., F.R.C.S.Eng., Assistant Surgeon to the Newcastle-on-Tyne Royal Infirmary.

COOPER, R. HIGHMAN, L.S.A., Assistant Medical Officer in the Electro-therapeutic Department, University College Hospital.

FEARNLEY, HAROLD, M.B.Leeds, Resident Medical Officer at the Leeds Public Dispensary.

GOUGH, A., M.B.Leeds, House Physician at the General Infirmary, Leeds.

LEGGE, J. H., M.B., B.S.Lond., House Surgeon at the General Infirmary, Leeds.

McCALL, EVA, M.D.Glas., Second Assistant Medical Officer at the Hull City Asylum, Willerby.

SINCLAIR, A. H. H., M.D., F.R.C.S.Ed., Assistant Ophthalmic Surgeon to the Edinburgh Royal Infirmary, vice G. A. Berry, F.R.C.S.

TILLEY, HERBERT, B.S., F.R.C.S., Surgeon to the Ear and Throat Department of University College Hospital, London.

WALTERS, B. ELINOR, M.B., B.S.Lond., House Surgeon at the York Dispensary.

Births.

UNWIN.—On Nov. 10th, the wife of W. H. Unwin, M.D., Timaru, New Zealand, of a son.

Marriages.

ENTRICAN—JARROW.—On Nov. 11th, at Rangoon, Major J. Entrican, I.M.S., son of the late S. Entrican, of Belfast, to Amy M. Jarrow, ex-Matron of Woodford Jubilee Hospital, daughter of the late G. E. Jarrow, M.D., Barrister-at-law, London.

Deaths.

BARKER.—On Nov. 11th, at Bedford, Laura Elizabeth Barker, of Staincliff, Sandown, Isle of Wight, eldest daughter of the late T. Herbert Barker, M.D.Lond., F.R.C.S.Eng., F.R.S.Edin., of Bedford.

SERS.—On Nov. 9th, at 119 Round Hill Crescent, Brighton, Robert Sers, M.R.C.S.Eng., aged 69, Late of Epperstone, Notts.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, NOVEMBER 22, 1905. NO. 21.

Presidential Address
ON THE
STUDY OF LARYNGOLOGY AND RHINOLOGY. (a)

By ROBERT H. WOODS, M.B., F.R.C.S.I.,
Surgeon, Throat Department, Richmond Hospital, Dublin.

GENTLEMEN,—The special study of laryngology and rhinology is young, and we are still pioneers; the field has no limit, and there is no finality to our art. It follows from this that, though we are advancing in a body, yet each will have his small portion of ground better known to him than to his neighbour. It is at once his duty and his privilege to extend his knowledge to his brethren, receiving theirs in return, as well as the benefit of their candid criticism if he appears to them to be working on wrong lines.

Nothing is so fatal to true progress as working alone; without intercommunication with his fellows the best man becomes provincial, if not parochial; he has no standard whereby to measure either himself or his methods, and if he advances at all it is only at an expenditure of energy quite disproportionate to the result obtained. From an economic point of view, therefore, membership of an Association such as ours is of the first importance to men who want to keep abreast of the times. But this is not all. If we are to mature our judgment and develop our self-reliance in dealing with obscure and perplexing cases, intercourse with men who are wont to be similarly situated is essential. It is hardly necessary to labour the point, but I am sure we have all suffered from the inherent difficulties of border cases, that immense class where the dividing line between two opposite courses is indistinct. The old proverb that "two heads are better than one" has the justification here. It is often a matter of no small difficulty to decide where the normal ends and the pathological begins. This is especially the case when the question of normality turns on the degree to which a condition is present. I shall mention adenoids, turbinal hypertrophies. and deflected septa, not as the most puzzling, but as the most elementary examples to illustrate my meaning. The transition from absolute normality to flagrant abnormality is often so gradual that the boundary between those cases needing treatment and those in which treatment is gratuitous must necessarily be somewhat arbitrary. And though in the end each must decide the question in a particular case for himself, his judgment will be helped by discussion with others whose opportunities of forming an opinion are quite equal to his own.

But when we come to consider the propriety of operating in a given case of cancer or sarcoma, we can see, not only the difficulty attending border-line questions, but the magnitude of the issue that turns on our decision. At what point in the history of a given malignant tumour does it become inoperable? Here again the ability, the dexterity, and the pluck of the operator enters so largely, that each must in the end decide the question for himself, but who will say that the sight of another man's success does not nerve and inspire him to attain similar ends, while the no less instructive cause of his failure will forewarn and forearm him against the dangers that beset his path? For reasons such as these it is a duty as well as a privilege to belong to an Association of members devoted to our particular speciality, not merely nominally, but actively, if we are to advance towards complete mastery in our craft.

It is pleasant to observe that within the last few years an improvement has taken place in the attitude of the profession at large to our speciality. Laryngology has advanced from tolerated dependence to a position in no way inferior to that occupied by any branch of the profession. That its development provoked a certain amount of hostility in men who could not see the necessity for its existence was natural enough. Nor is it surprising that they should have concentrated their criticism on certain operations the propriety of which is now unquestionable. Take the case of deflected septum. It is not on the face of it obvious why a deformity, especially if not visible to the naked eye, should be interfered with at all; and if some of the older practitioners could not see the precise way in which such conditions cause discomfort or disease, we cannot blame them for looking with a sceptical eye at operations for their remedy, nor need we wonder that the more censorious of them should have regarded the operator as of doubtful morality. We must be tolerant of such scepticism. Scepticism is with us a duty, and we must not deny it to our critics. It is a quality too valuable and too scarce to be repressed, and if it now and again prevents us from embracing the truth with "hail fellow well met" promptitude, it at least saves us from that open-mouthed acceptance of nostrums and fads, which is the inalienable privilege of a free-born, if imperfectly educated and too credulous public. What a godsend a little of it would have been to those who a few years ago believed that Count Mattei's green and blue electricity could "cure incurable disorders." What a godsend it would now be to those queer people who call themselves Christian Scientists.

A friend of mine, on hearing of the wonderful result that followed the administration of some drug in a case of cancer of the stomach, remarked, "You know you can cure any disease if you only make a wrong diagnosis."

In our speciality, as elsewhere, the tendency of late years has been more and more towards the treatment of disease by surgical means. For my part, I am heartily of opinion that this is a step in the right direction. Not, indeed, that we have much choice in the matter, for while men are earnest, the best method will beat others out of the field, so that sooner or later the question of what is the best method will be settled automatically. But, pending that tranquil moment, we must try to show men the error of their ways when we find them trying to cure hypertrophic cases and cases of sinusitis, by washes or snuffs, either of their own prescribing, or, what is more pernicious, because more weak-minded, the prescription of proprietary compounds. It seems only necessary to advertise these proprietary articles with sufficient persistence in order to popularise their employment, while their number and evanescence are satires on our credulity. I do not, however, mean that because a drug is new and advertised and proprietary it is necessarily valueless. There is one brilliant exception—adrenalin or its equivalent under other names. I think you will agree with me when I say that this is the most important addition to our list since cocaine. But even here, or rather particularly here, since it has such excellent qualities, it is necessary to say a word of warning against its indiscriminate use. The fact that it possesses the property of blanching mucous membranes has seduced people into prescribing it for use by the patient in inflammatory cases, specially acute rhinitis. The reasoning is superficial, for a moment's thought will show us that this very inflammation which so annoys the patient is nothing more or less than the reaction of the tissues to bacterial invasion and is in fact the very means whereby that invasion is repelled. The cause of inflammation may be a thing to regret, the thing in itself certainly is not, and to repress it artificially by means of such a drug as adrenalin can hardly fail to aid the bacteria in their attack on the tissue in question. For this reason I have never used the drug for any except surgical purposes, but I have seen and heard enough of it in the practice of others to confirm me in my opinion.

(a) Presidential Address to the British Laryngological, Rhinological, and Otological Association, delivered at the Opening Meeting, Nov. 10th, 1905.

Perhaps the most striking new feature of operative work in our speciality, and especially in the nose, is the magnitude of the operations performed under local anæsthesia. To the difficulty of administering a general anæsthetic through the seat of operation must be added the drawback that in the vast majority of cases the operator is robbed of the most valuable help he can have to the accuracy of the operation—viz., the co-operation of the patient. Hence the superiority of local anæsthesia when it can be employed, and hence, also, the increase, actual and relative, in the number and importance of the operations performed in this way. Now, anything that tends towards the comfort of the patient and the convenience of the operator during the progress of the work is too important to be neglected, and it seems to me surprising that the ordinary domestic chair, which was pressed into the service when the laryngoscope was first invented, should still persist in the all but universal way in which it does. For the last three years I have been using a dental chair, with one or two unimportant modifications. Among the more salient of its advantages are: (1) the ease with which it can be raised and lowered to suit the patient to the operator; (2) the fact that the operator can get more intimately at his work; (3) the avoidance of any constraint in the operator's posture—a matter of no small importance in prolonged operations; (4) the rapidity with which the patient can be brought to the horizontal position in case of nervous or toxic syncope; (5) the patient's position is one of complete rest.

I have now fairly tested its merits both in private and hospital work, and I have no hesitation in saying that for operations such as resection of the septum, the extraction of polypi or the intranasal treatment of sinusitis, it is as much superior to any laryngological chair that I have ever seen as a modern operation-table is to a four-poster bed. I believe it only needs a little practical acquaintance to popularise its use as an aid to those operative methods in the treatment of disease, which have advanced so rapidly in the past, and of which we have such promise in the future.

But while it is out first duty to cure disease, we must spare a thought and lend a hand for its prevention. We all know the difficulty of rousing people into taking steps to avoid or avert the danger that we can sometimes clearly foresee. The waking-up process is always an unpleasant one, and people prefer the attractions of a fool's paradise to the discomfort of a wise man's hell, and though a good deal is being done to prevent diseases of the throat and nose, much still remains. One of the commonest, as it is the most easily recognised and the most easily prevented, causes of throat disease is oral sepsis. Neglect of the teeth by the patient is a fruitful source of this condition, and I do not hesitate to say that a more fruitful source is to be found in neglect of elementary hygiene by those incompetent dentists who fit artificial contrivances over septic areas.

In spite of what has already been done, public opinion, both lay and medical, still needs rousing on this important subject. People do not exercise their common sense, or they would cease to expect healthy throats, not to say bodies, to co-exist with dirty mouths. But, even discovering the cause must not content us; we must get at the cause of the cause. We must ask ourselves why teeth are prone to decay, and gums to inflame. These are vexed questions, but they are of national importance, and the sooner the correct answer is found the better for the race. It is no part of my function to-day to guess at the answer, but I may express my belief that the cause will be found to be very largely a dietetic one, especially of those years in which the teeth are being formed.

Of preventive medicine as applied to the ear there is little to be said, but that little is of the first importance. We are still in blank ignorance as to how to avoid chronic middle-ear deafness. We are not in much better case with regard to deafness of auditory and internal ear origin, but when it comes to chronic suppurative otitis, our position is different, and I was glad to see the subject received the attention it so well deserves at our section of the British Medical Association this year, which I was unfortunately unable to attend. It is now nine years since I first actively interested myself in the subject and undertook an investigation into the relation of middle-ear disease to measles and scarlatina. During the epidemic of 1896-7 I daily examined the ears of all such patients in the Hardwicke Fever Hospital. The number of patients was considerably over 300. I have seen no reason to modify the conclusion at which I then arrived, and which I shall quote from the *Dublin Journal of Medical Science* for January, 1898:—

"A comparison made between any of these (specimens of pus from acute otitis in measles or scarlatina) and pus from a chronic suppurative case that had originated in an exanthem, established the contrast, that whereas in the acute condition there are rarely bacteria of more than one kind present in quantity (generally a diplococcus), in the chronic there are to be seen several, notably bacilli, spirilla, staphylococci and streptococci, none of which are proper to the condition. This at once raises the suspicion that one or more of these latter forms gained entrance to the tympanum through want of proper precautions during the attack, and having established themselves there, kept up the flow of pus indefinitely, the bacteria which started the otitis having worn itself out. It requires but little consideration to show the likelihood of this, for the discharge acts as an excellent culture ground, providing moisture and pabulum at the ideal temperature for growth and reproduction, and furnishes a track from the point of infection back to the tympanum, along which the microbes can extend at their leisure.

"From what I have observed I have no doubt that this is what happens, and that it requires, in an ordinary case, little more than elementary cleanliness, in order, by preventing this epi-infection, to insure that the inflammation may subside and the membrane heal in a few weeks, leaving the patient little, if any, the worse either in health or hearing."

Following this conclusion, the practice at the Hardwicke Hospital for the past nine years has been to thoroughly cleanse the ears by syringing with creolin lotion in every case of measles and scarlatina, immediately on admission; in fact, it is regarded as part of the bath. Then, if the ears suppurate they are syringed carefully and frequently, and filled once daily with a saturated solution of boric acid in 50 per cent. spirit. Since this plan has been adopted, it has become quite uncommon for patients to leave the hospital with suppurating ears. This can hardly be mere coincidence.

Of course, exceptional cases will occur when no precaution can prevent chronicity, tuberculous cases, and those fulminating ones where the virulence of the inflammation is so great as to cause necrosis of bone, &c., but we are probably well within the limit of truth when we say that these do not form 10 per cent. of the chronic suppurative otitis, and that the remaining 90 per cent. were at one time preventible. It is matter of everyday observation that when a patient comes under treatment for acute otitis, either in time for paracentesis, or directly after rupture of the drum, one seldom or never sees a chronic result. The golden opportunity in such cases offers itself before any organisms other than those that started the inflammation gain access to the tympanum; if this is seized, and the meatus kept free from pus, one may expect the diplococcal infection which occurs in the vast majority of cases to heal in three weeks. I have known a mixed infection by staphylococcus aureus and albus heal under the same treatment, but after a longer time.

I shall only touch on one other point, one that is elementary, but not trivial—the syringing of the ear. Syringing is no good unless it removes the pus from the meatus; it therefore behoves us to see that whoever does it really knows how it should be done. One or two failures or omissions may result in the calamity of epi-infection, especially in children and others who do not understand the importance of keeping their fingers away from the ear. An acutely suppurating ear, notwithstanding the fact that it is purulent, should be guarded from infection as jealously as an abdominal wound. Personally I am in favour of an alkaline solution such as bicarbonate of soda for use as a lotion, on the ground that it emulsifies the mucopus better than a neutral or acid one, while for the antiseptic effect I rely on boric acid and spirit.

In conclusion, it may be remarked that while, perhaps, none of the points mentioned need be insisted on in a society of specialists, yet, until the truth of them is grasped as firmly as in the general ranks of the medical profession, the repetition of them remains an imperative necessity.

THE MANAGEMENT OF THE INSANE IN AUXILIARY ASYLUMS.

By J. O'CONOR DONELAN,

Deputy Medical Superintendent, Portrave Asylum, co. Dublin.

Of the increasing number of insane persons confined in our public asylums and kindred institutions throughout the country much has been said and written. While public opinion has awakened to the necessity of providing suitable accommodation, care and treatment for the mentally afflicted, the expense of doing so has called forth much grumbling from the taxpayer and his representative on asylum and Poor-law boards. In truth, it can hardly be said that these grumblings are unreasonable, based as they are on statistics which show that expenditure on the insane has been steadily mounting up year by year with little indication that we have yet reached the line of fixed proportion between the sane and insane. Various suggestions have been made and plans elaborated with a view to checking this growth of expense, and the one which has met with the greatest favour is that to establish auxiliary asylums wherein chronic harmless lunatics should be maintained at a cost much below that prevailing under the existing system. It is asserted that there are many lunatics who require but little attention, and that they need not be detained in establishments equipped to deal with the violent, destructive and other expensive classes.

The population of a general asylum is made up of all sorts and conditions of patients who at one time or another were such a source of trouble to their friends or the public as to lead to their committal. But great as the variety of mental disease or degeneracy so also is the cost of maintenance and care. There are those requiring the closest medical supervision and special attention of nurses by night and day, for months at a time, even for years in some instances; such cases are, of course, enormously expensive, and no doubt if accounts were kept showing their cost the figures would be a shock to the average ratepayer. Next we have patients of destructive tendencies; there are those of filthy habits, epileptics, the sick, and infirm, and so on, until we come to the harmless working patient who is often a source of profit, rather than loss, to the institution. These latter do the bulk of the heavy farm, garden, and artisan work as well as much of the general cleansing of the asylum, so that if accounts could show their cost and allow for the value of their work, a pleasing set-off against the expensive cases referred to above would be available. Clearly, then, if these harmless lunatics are taken to a separate asylum, which it is agreed to run on the cheapest lines, it is not too much to expect that the maintenance rate should be extremely low, if sufficient field could be found for profitably utilising their labour. But even then the advantage to the ratepayer would be only apparent, because the work that had previously been done by these patients in the general asylum should now be carried out by paid hands and the cost increased accordingly.

In England some experiments were made along this line, but the result has been a reversion to the original system which utilises the working patient to the greatest advantage, and at the same time affords him the best chance of mental improvement and of ultimately regaining his liberty.

It must not be forgotten that melancholia in one or other of its many phases is by far the predominating mental symptom we have to deal with, and in every well-managed asylum one of the first aims is to brighten the lives of the unhappy sufferers, and create hope of ultimate restoration to health and liberty. What, then, must be the effect on patients when they find themselves transferred to the auxiliary or chronic home. The change is not likely to give much encouragement.

So far I have dealt only with the case of the so-called harmless lunatic of the asylum; unfortunately we still have a large class mentally afflicted, who, chiefly, because of their passiveness, have been overlooked to a great degree. These are idiots, imbeciles, dements and children of mental deficiency who are now detained in what are known as the lunatic wards of our workhouses. The miserably neglected condition of these wretched beings is truly a reproach to humanity. That something may soon be done to ameliorate their state is, indeed, a consummation earnestly to be desired, and it would seem that the auxiliary asylum system should have its field of utility in this connection, by combining a number of workhouses so that the auxiliary would be of sufficient size to allow of classification, each class could be treated on the most humane and economical lines. For the senile dements and paralytics infirmary care would be necessary, for the adult idiot or imbecile, cleanliness, good plain food, protection from cold, and, if he is comfortable, his claims are satisfied. The epileptic is at all times an anxious case, who must be well attended to. But of all the classes the one deserving the utmost consideration is that of the weak-minded children, for it is astonishing how much can be done to improve those helpless little creatures when they are systematically and sympathetically taken in hand by one skilled in this very special branch of training. The neglected weak-minded child grows to be a helpless idiot, while he who has been properly cared and trained has a far brighter prospect probably to the extent of becoming a somewhat useful individual.

Now, an establishment in which all this is properly carried out cannot be a particularly cheap place to work, although structurally it might be of the simplest design. Training weak-minded children and infirmary care for senile cases involve expense, and the management of epileptics and idiots involves more work than is generally supposed. Nevertheless all that is desired could be done at a figure which would show an economy in comparison with the general asylum cost.

The great difficulty in carrying out any scheme for establishing asylums in connection with workhouses is chiefly due to financial complications arising out of the variations of cost and rates in different unions. For this reason direct combination even for asylum purposes is an unlikely development. Through the medium, however, of the district asylum, a working arrangement should easily be arrived at, and there can be no doubt that the committees are in a position to conduct the auxiliaries on the best and most economical lines. An auxiliary in proximity to a general asylum would have much in common with it, separate clerical, medical and mechanical staffs would be unnecessary, and assistance to those existing would only be required. The inmates of the new institutions being purely of the more or less idiotic types, much of the routine observation and recording which is essential in the treatment of cases of ordinary mental disease, might be dispensed with. A lower proportion of nurses and attendants to patients would suffice. By combining the general and auxiliary asylums, patients could easily be transferred from one to the other as occasion might require; thus an impulsive idiot during his period of violence might be sent to the general asylum, and when quiet, return to his normal habitation. Under the present system, such a case, when he becomes violent, is committed to the district asylum, and as he never attains the line of mental balance that would warrant his discharge, he remains for the rest of his life an encumbrance on the institutions' resources.

Committees who have already incurred heavy expenditure on buildings are naturally disinclined to undertake more in that direction, particularly as their experience has generally been with more or less elaborate structures. Now they find it hard to believe in the possibility of building suitable but plain accommodation at the moderate figure of about £70 per bed. It would, of course, be impossible to establish independent asylums at anything like that rate, because in addition to the wards, officials' quarters, lighting station, water supply, &c., would be necessary.

Seeing that whatever may be done in this matter, whether by the asylum committees or the Poor-law guardians, the cost must be met by the ratepayers, and as the asylum committees are in the position to produce the maximum of effect at the minimum of cost, it would seem that it is for them to give the matter their immediate and very earnest attention.

ON THE

VALUE OF EXAMINATION OF THE BLOOD DURING TYPHOID FEVER.

By JOHN ATKINS, M.B., F.R.C.S.

The value of a leucocyte blood-count as an aid in the diagnosis of typhoid fever is well recognised. The following case illustrates the aid which an examination of the blood may give during the course of the disease, more especially with reference to the complications. A well-developed man, æt. 24, who was suffering from a severe attack of typhoid fever, suddenly developed symptoms of collapse on the first day of the third week of the illness. The previous day he had been in a dull, listless condition, slightly delirious during the night, with trembling of the arms and twitching of the fingers, his temperature remaining about 102° F. with a pulse of 112, small and slightly "running" in character. At three o'clock in the afternoon he became suddenly pale, quite unconscious and large beads of perspiration stood out on his forehead. The face soon became of a dusky hue, the temperature fell rapidly to 99° F., and the pulse, which was almost imperceptible at the wrist, reached a rate of 128. A subcutaneous injection of strychnine was given at once. The nature of the collapse was then considered. The conditions which came at once to the mind were hæmorrhage, perforation and acute heart failure.

Hæmorrhage was considered first. The period of the disease (the fifteenth day) and the rapid fall in temperature were in favour of this. No blood, however, was passed per rectum, and the specific gravity of the blood was found to be 1052. Thus it was extremely unlikely that any hæmorrhage sufficiently severe to produce the condition present had occurred, as such would have led to a distinct fall in the specific gravity of the blood. The question of perforation then arose. In favour of this were the sudden and severe onset at the beginning of the third week of a grave attack of typhoid fever, in which meteorism had been a prominent feature; the rapid fall of temperature, the sweating, the rapidity of the pulse, rigidity and distension of the abdomen, and absence of liver dulness. A physical examination was not, however, of great value, for the patient being unconscious no indication of pain on pressure could be obtained and the liver dulness had been absent twenty-four hours previously owing to tympanites. There were no abnormal physical signs in the lungs.

A blood-count was then made and the leucocytes found to be just about 7,000 per cubic millimetre. This strongly contraindicated perforation, for with this complication there is in most cases a marked leucocytosis within half an hour of its onset. In those in which perforation had occurred and no leucocytosis has been found the patient has been in a markedly debilitated condition (such as might result from a prolonged illness) and there is no leucocytal reaction. In this case, however, the patient was a remarkably well-developed man, æt. 24, who had been ill but two weeks, and in whom a leucocytosis would have been justly expected in case of perforation.

The absence of any marked increase in the number of leucocytes present also confirmed the view that hæmorrhage had not occurred, as with this complication there is generally a considerable increase in the number for some time subsequently.

By the time the blood-count was finished a physician of wide experience saw the patient. From the examination he made he considered that perforation was the most likely cause of the collapse, but confessed that the leucocyte count, if trustworthy, strongly indicated otherwise. A second count was made in his presence, and again the leucocytes were found to number about 7,000 per cubic millimetre. He then said that under the circumstances the best advice he could give was that if no leucocytosis occurred the case had better be treated as one of heart failure, whereas if any marked leucocytosis developed laparotomy should be performed.

Accordingly, a leucocyte count was made every hour for the next fifteen hours, that is, till six the following morning, and in no one instance did the leucocyte number more than 9,000 per cubic millimetre. In the meantime, the heart condition was met with repeated injections of strychnine. No laparotomy was therefore done, and in about twenty-four hours the patient rallied, and from that time onward made an uninterrupted recovery. He was seen several months subsequently, and was quite well and working regularly.

The chief points illustrated by the case are:—

(1) By determining the specific gravity of the blood hæmorrhage was negatived. The practical value of this was shown in the subsequent treatment, as cardiac stimulants could be employed at once without any fear of increasing hæmorrhage.

(2) The leucocyte count, made at regular intervals

over a considerable period of time, prevented a laparotomy from being performed. As the patient was evidently suffering from acute heart failure, this abstention from operation probably saved his life.

PROGNOSIS OF PULMONARY TUBERCULOSIS,

By T. CARSON FISHER, M.D., M.Ch.,
Paignton, S. Devon.

Dr. A. Latham in his practical book on "Pulmonary Tuberculosis," writes: "A wise physician never gives a prognosis in a case of tuberculosis. This rule is a difficult one to follow in practice, but no opinion should be expressed until we have the patient under observation for a considerable time, and have thoroughly mastered the individual peculiarities of the case."

Those who are most familiar with consumptives and their ways will readily endorse this opinion.

In a disease often latent, mostly chronic, liable to periods of remission and intermission, where the *vis medicatrix naturæ* is constantly at war with opposing influences, accidental or otherwise, variable in its course, and marked by clinical surprises, no wonder mistakes are made, and the forecast baffles the unwary. Experience teaches that the problem is often difficult and sometimes insoluble. A timely suspense of judgment or a merely provisional opinion is at first advisable, until time is given for careful observation. The reasons for this difficulty are not far to seek.

The measure of the virulence of the tubercle bacilli and its toxins, the conditions for or against their growth in the human body, the influence of mixed infection, and the power of resistance, are all uncertain, beyond the scope of test tube or microscope. Added to these are the "abysmal depths of personality" which increase the sum of difficulty. It is true that pathology shows that the disease is widespread, affecting perhaps a third of humanity, and that in a large percentage of cases it is outgrown or spontaneously curable.

Bacteriologists have tried to estimate the virulence of the toxins, or the power of resistance to them.

Giassano, of Turin, has found that in tuberculosis of children the proportion of eosinophile leucocytes increases as the patient improves, and lessens where there is fever, cachexia, &c. (*B. M. J. Epitome*, p. 56, Oct. 15, 1904.) Dr. A. E. Wright and others have shown that the phagocytic reaction of the patient's blood, and what they term the "opsonic" value of the serum, whereby the bacteria are rendered suitable prey for the phagocytes, can be estimated and compared with that of normal blood. The rise or fall of the "opsonici index" under treatment indicates the course of the fight between the forces of the human organism and the opposing germs. Whether this research is of practical value in aiding a prognosis remains *sub judice*.

The evidence of pathological stages given by physical signs is very uncertain, for they may vary from day to day, and the phenomena of the disease follow no stereotyped course. Skilled observers teach that the affected area is always more extensive than the physical signs show. Hence he who relies on these alone is sure to fail.

Since infection with tubercle bacilli is the cause of the disease, the character of the soil which allowed the bacillus to grow is one of the first questions. Much has been written on Predisposition—hereditary and acquired. Some are handicapped in the battle of life by tainted ancestry. The family history of consumptives shows this only too frequently. Of recent years a less gloomy view has been taken of the effect of such ancestry. Hereditary transmission is so rare as to be almost negligible. Some think that the hereditary vulnerability, the fit soil for the tubercle bacillus, is not a bar to recovery. Mason King, of New York, and others argue that the offspring of tuberculous parents show greater resistance, and recover better than other persons. This seems to contradict general experience, or to explain such well known facts as "family phthisis," but it is worthy of further research. A good family history, in the view of most, is not a negligible factor in prognosis. In the strain and stress of modern life, the acquired predisposition due to bad environment is only too common. The way a patient improves when removed from such surroundings and put under proper hygienic treatment is often a guide to prognosis.

Burton Fanning and others maintain a theory of latent tuberculosis. "A large portion of the population always have living tubercle bacilli buried somewhere in their systems, but disease only manifests itself when something occurs to lower the host's power of resistance." It certainly seems as if some patients have been potentially consumptive for years, and direct infection cannot be shown in many cases. This evidence of feeble resistance aids prognosis. After consideration of the family and personal history, one may try to estimate the differential value of such pressing symptoms as cough, hæmoptysis, sweating, and various complications.

Cough is one of the most common and troublesome of symptoms. The patient whose rest is disturbed by frequent paroxysms of hacking cough, with scanty expectoration, due in many cases to reflex causes or irritability of the respiratory centres, or whose sputum is profuse, is not as good a case as one who coughs little. In some the mucous membrane of pharynx or larynx is at fault. In others dyspepsia is the cause, so-called "throat" or "stomach" coughs. Such may yield to appropriate treatment. If all sources of reflex cough have been examined, and it still persists, the inference may be made that the disease is progressing insidiously, but steadily.

Hæmoptysis probably occurs in about 50 per cent. of consumptives. Unless frequent or profuse it is not necessarily unfavourable, though there are serious hæmorrhagic cases. In no case is it unimportant. The cause and source should be investigated, so far as is possible. It may be due to over-exertion, or want of proper rest. Severe attacks occur sometimes when the patient seems doing well, and putting on flesh. Hence the ultimate prognosis is sometimes problematical.

Sweating is often met with both in the early and in the chronic form of the disease. It may occur when fever is slight, or when it is high. It often ceases when the patient is put under open-air treatment, and his power of resistance is thereby improved. If it persists in spite of treatment, and is excessive, it is a bad sign.

Complications.—These, both thoracic and non-thoracic, are numerous and frequent, and their influence in accelerating or retarding the original disease has to be considered. Hence the personal history is important as showing the patient's power of resistance. Attacks of so-called influenza or bronchitis are very suggestive. Pleurisy occurs frequently in consumptives, and a liability to such attacks retards if not prevents recovery. Osler states that about 30 per cent, of pleuritic cases become tuberculous. (*B. M. J.*, p. 1,001, Oct. 15, 1904.)

A chronic bronchitic or asthmatic patient with tuberculosis superadded has generally a poor chance of recovery. Laryngeal combined with pulmonary tuberculosis is not often favourable, unless timely open-air treatment and proper rest are attained. The neurotic, the alcoholic and the restless are heavily handicapped. Vomiting, anorexia, or dyspepsia, especially in elderly patients, if long continued, are unfavourable symptoms; whereas the good trencher man, whatever his other troubles may be, has a better chance of improving his resisting powers. Bad teeth are very common in consumptives, and the aid of the dentist is too often deferred. Any complication in a consumptive that adds to the constitutional derangement must not be lightly dismissed, and due consideration even of minor ailments helps prognosis.

In a survey of the effects of the disease on the system, the value of right interpretation of the temperature, circulation, and nutrition is essential. The temperature and pulse chart indicate the type of the disease, and periodical weighings help to show how nutrition is affected. The phenomena of mixed infection can also be inferred, and such observations are all-important for prognosis. Thus a normal day temperature, with little evening rise and increase of weight, indicate quiescence of the disease, while constant pyrexia, if persistent, indicates active mischief.

The physicians of former days wisely laid great stress on the pulse, and it is generally true that a rapid pulse of feeble tension, even when the patient is kept at rest, persisting week after week, is a bad sign. The effect of open-air treatment on the pulse and temperature during the first few weeks is very significant. Burton Fanning, in his book, lays stress on the power of rest and fresh air in reducing fever, and indicates how this may help prognosis. If after six weeks or two months of sanatorium treatment there is no improvement, the outlook is generally gloomy. Increase of weight is not invariably favourable. Some gain flesh readily, though there are clear indications of advance of the disease. On the other hand, steady loss of weight is ominous. The concurrent symptoms and physical signs will show how far this factor is favourable or otherwise.

Physical Signs.—All authorities are emphatic in the need for caution in the interpretation of physical signs, which help to show the extent and activity of the disease. Thus, Professor Cornet, of Berlin, states that percussion is of little value in the early stages of the disease, since the size needed to alter percussion resonance must be 4 to 6 c.m., and 2 c.m. deep, and that weeks or months pass before this size is attained. He shows also that mistakes are frequently made about dulness at either apex.

The evidence of so-called stages is unsatisfactory as regards prognosis. The diagnosis of cavities is often uncertain; and though the evidence be clear, the constitutional symptoms may be slight. On the other hand, physical signs may show a limited area of disease, while the symptoms are unfavourable. A dry cavity may remain stationary for months or years, while the general condition is one of robust health. But as a rule the greater the area of disease, and the smaller that of unaffected lung tissue, the worse the outlook. Statistics show that where only one lobe or two half lobes are affected and there is no cavitation, the prospects are good, other things being equal.

Physical signs may not alter much, while the patient steadily improves, and *vice versa.* Hence the indications of skiagraphy as regards prognosis may be taken with some reserve. Mistakes are possible in the interpretation of physical signs; the pitfalls are many, and a wide experience is the only safe guide.

Duration and Course of the Disease.—Although the ultimate issue may be fairly clear to our vision, the attempts to forecast the time or course of the malady is sometimes mere surmise. No two cases run alike. Even in hopeful ones drawbacks occur of doubtful duration, while bad ones sometimes rally in a marvellous manner. There is no disease where an honest opinion of its gravity may be more safely given to the patient. An optimistic view is not always justified by events, and even where a hopeful opinion as to time and course may be reasonably given, the wise man will avoid being cocksure.

IMPORTANT FACTORS.

While we try to gain exact information as to the past and personal history of the patient by every means in our power, the main factors for prognosis are:—

1. Constitutional state.
2. Effects of the disease on temperature, circulation and nutrition.
3. Area of the disease, and the ability of unaffected lung to carry on respiration.

It is evident that repeated observations should be made, and only a guarded opinion can be given from one examination in most cases.

Of course, the destiny of the patient will depend in a great measure on his temperament, to which the older physicians attached more value than is perhaps the vogue nowadays. We are apt to forget that the course of the disease depends on the patient himself, on his patience and self-control, and how far he is amenable to the restrictions of invalid life. Thus the neurotic, reckless or alcoholic are heavily handicapped as compared with those of more stable temperament. Hence men do better than women, and also because they have more power of resistance. As this improves, the patient becomes more immune, and the tuberculous lesion walled off by fibrous tissue. Where there are cavities with cocci in addition to tubercle bacilli, ulceration takes place, and phenomena of mixed infection. Then recovery is more distant; though in sterile air, and aseptic environment, the tendency is for pathological organisms to become non-toxic. Hence the importance of long-continued open-air treatment, and the prognosis is influenced by such considerations.

Experienced observers like Dr. Knopf and others hold that the prospects of a consumptive treated out of a sanatorium are far worse than of those who submit to the necessary discipline. Very few patients can be trusted to order their lives to the best advantage unless they are under constant and skilled supervision. The record of cases admitted to sanatoriums testifies forcibly to this fact.

The most hopeful cases are those of fair family history and physique, whose general condition is not much impaired, fever slight, digestion fairly good, area of disease limited. If the disposition is equable and cheerful, the outlook is all the better.

Not so favourable are—

1. Age under puberty, or elderly.
2. Temperament neurotic or melancholic, the alcoholic, reckless or excitable.
3. Marked impairment of general condition.
4. Area of disease extensive or increasing.
5. Frequent or profuse hæmoptysis.

For practical purposes the varied destiny of the consumptive may be summed up as follows :—

1. Complete arrest, where the patient can enter again on the toils and joys of existence, provided he leads a modified open-air life.
2. Partial arrest, where with care and open-air methods, untaxed by arduous exertion or strain, he may live in comparative comfort many years.
3. Chronic invalidism of uncertain duration.
4. Hopeless cases.

Often the solution of the problem of prognosis can only be approximate. Many will agree with Walsh that there is no stage of the disease which is surely curable. Most authorities admit that, so far, sanatorium treatment, though not a specific, gives the best chance of recovery, however crude or imperfect it may seem. Some doubtless regard it as a passing craze, an opinion which may be rectified by wider experience.

However that may be, so widespread is the disease, that most of us are frequently called upon to give a prognosis. If the wisest is he who makes fewest mistakes, even the humblest of us can seek after wisdom by learning from his own mistakes and those of others.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting held Thursday, November 9th, 1905.

Dr. William Alexander, President, in the Chair.

Specimens and Notes.

Dr. Macnaughton-Jones, junr., read the following notes on a specimen of

EARLY TUBAL HÆMATOCELE.

The case has certain clinical, anatomical and pathological points connected with it which I think make it worth recording. The patient, æt. 23, unmarried, was seen by me, with the following history and symptoms :—The catamenia had been regular, and the week before she had passed through a period which had been unusually profuse. After it had ceased she suffered from abdominal pain and tenderness. This was attended at the time by a rise in the temperature and pulse, and some distension of the abdomen, which was still somewhat tympanitic ; but there was little pain, the pulse had fallen, and the temperature was normal. She was very blanched in appearance. The pelvic examination revealed a small uterus, quite movable, and normal in position, a short conical cervix, and a slight fulness in the right fornix. Nothing could be felt bimanually, and there was no pain. The pouch of Douglas was empty. There being no pelvic symptoms, it was decided not to interfere, though the possibility of an ectopic gestation was discussed. The following week she continued to improve, so much so that she was permitted to get up. On making some slight exertion when lying on the sofa she suddenly complained of great pain, and symptoms of collapse followed. I saw her the next day. The pulse was then 140, and the temperature had risen to 103°. She was quite blanched, and the abdomen was greatly distended and dull. A soft mass now distended Douglas's pouch, pushing the uterus up out of the pelvis. Altogether, her condition was extremely critical. As soon as a room could be prepared, I operated. She had a strychnine (one thirty-sixth) and atropine (one hundredth of a grain) subcutaneously half an hour before operation, but her state when placed upon the table was about as bad as it could be. On opening the abdomen a quantity of blood escaped ; it was full of clots. Many of these, in the pelvis, were adherent to the bowel and surrounding parts. On exposure of the broad ligaments, it was found that there was bleeding at both sides, but the most profuse flow came from the right side. The pelvic cavity was small and rather difficult to manipulate in. The rent on the right side ran across to the posterior surface of the uterus and down to the vaginal roof. The right tube was saccular. It was not easy with the defective light to see the bleeding points or surfaces, which were further obscured by small portions of adherent and partly organised clots. Clamps were passed at either side, which included the tubo-ovarian and uterine vessels. The former were first secured at the left side by gut ligatures. The right broad ligament was distended with blood. The arrest of the bleeding at this side was extremely difficult, and even after the tube and ovary were removed the blood welled up freely from the floor of the pelvis. I then determined to ligature both uterine vessels, and remove the uterus (supravaginally), that I might thus gain room and have a clearer view. When this was done the bleeding practically ceased. Saline rectal injections were given at intervals during the operation. As there was still some oozing, a Mikulicz drain of sterilised iodoform gauze was carried well down to the pelvic floor. This was removed after thirty-six hours and a rubber tube inserted. There was no further hæmorrhage. The patient made a perfect recovery.

The following points in the case are worth noticing :—

Clinical.—The absence of any marked local signs of pelvic trouble after the first attack, and the deceptive improvement in the patient's condition. This, I think, is explained by the bleeding assuming the character described by Taylor as "blood-drip," and a temporary sealing of the rupture. The blood must have been in a fluid state when I first saw her. The larger rents must have occurred subsequently. Exertion evidently caused the second lesion and rapidly brought on the alarming, almost fatal, hæmorrhage.

Anatomical.—The rupture occurring at both sides, and the larger rent at the right side, which ran transversely and then diagonally down the ligament.

Pathological.—The pathological report is as follows : "The right tube is dilated by blood clot and is enveloped by fibrinous clot and blood-stained lymph. It is roughened on its posterior surface. The ostium is patent and admits a crow's quill. Its promixal end is impervious. It has been examined microscopically, and is found to be distended with blood clot in which one or two degenerate chorionic villi are found. The seat of the impregnation, therefore, was the tube, and not the ovary. The mesometrium is thickened, rough posteriorly, smooth anteriorly. The right ovary is small, and contains a lutein cyst in its centre, within is a solid mass of tissue to be examined microscopically. The yellow body found lying in a cystic space is a condition which has never been described, but of which during the last two years I have noted several examples. It consists of the entire contents of a corpus luteum, *i.e.*, central organising clot and peripheral lutein tissue. The separation has occurred through the theca interna, parts of which can be seen still adherent to the lutein cells which invest the yellow body. This structure is of no clinical significance. The left ovary is about normal in size. It has attached to it a broad thin membrane, blood-stained and roughened on one surface, and smooth on the other, which is obviously the parametrium, but no tube is attached. This ovary is studded with normal corpora albicantia, and its cortex contains a vast number of primordial follicles. There is no gross abnormality in this gland."

Professor J. W. **Taylor** said that Dr. Macnaughton-Jones's specimen appeared to be a case of very early rupture. But it certainly was very unusual that a menstrual discharge should occur within one week of the date of rupture.

SOME INTERESTING CASES OF NEPHRECTOMY.

Professor **Taylor** showed specimens from three cases of nephrectomy. He said that tumours of the kidney were not strictly gynæcological subjects. But they occurred in women, and he had had some rather interesting cases which he now brought before them. The first case was a tumour of the right kidney at the lower part of the anterior surface. It occurred in a woman, æt. 53, married, who had six children; the youngest was fourteen. The menopause occurred ten years ago. The peculiarity of the cases was that there were signs of distended gall-bladder. The patient had severe attacks of abdominal pain on the right side spreading over the abdomen, which usually lasted six hours and were attended with vomiting. Twelve attacks occurred during the last three weeks before admission. A provisional diagnosis was made, either gall-stone colic or malignant tumour of the colon. This diagnosis was justified, as there was a distinct lump in the right hypochrondrium which appeared to move apart from the kidney and could be felt behind. In operating he opened the abdomen by making the usual right lateral incision for gall-stone or distended gall-bladder. The tumour was underneath the peritoneum and appeared to be involving the colon. He then made an incision in the loin and found that the tumour was growing from the anterior and lower end of the right kidney, but intimately adherent to the colon. It was very difficult to separate the colon from the kidney. He was unable to say what the tumour was, but it probably was a malignant tumour. The second tumour was one of tubercular disease. This occurred in a woman, æt. 40, who had six children, the youngest being three years old. Her father's brother and sister and the children of the latter were tubercular. The patient was bedridden, emaciated, and had symptoms of cystitis. On examination he found that the right ureter was hard and thickened. He made a diagnosis of tubercular disease of the right kidney and ureter. Max Sänger and Kelly stated that in tubercular disease of the kidney and ureter the latter could be felt as a hard cord as it passed to the bladder. He removed the kidney, with an abscess in the upper part. As much of the ureter as possible was removed through an incision in the loin. Afterwards there was much improvement, and she was able to travel a distance of thirty miles. There was probably tubercular disease of the bladder as well. The third case was an interesting one of pyonephrosis. The patient, a woman, æt. 37, with two children, the youngest being five, had a history of passing pus in the urine for three years. There was a tumour in the right hypochondrium, which he removed last September, and the patient was now perfectly well, and had no albumin in the urine. Apart from the clinical interest of these cases there was another interesting point to which he would like to draw the attention of the Fellows, and ask their experience on the matter; that was the use of the segregator in determining the character of the urine from different kidneys. Scientifically, the best way was catheterisation of the ureter, but he often found it to be a disagreeable proceeding. In cases of foul purulent cystitis and of tubercular disease there was some danger of carrying infection to a sound ureter or sound kidney by the catheter. He used the segregator in the case of tubercle and in that of abscess; in the former he found pus on the right side and clear urine on the left, but on both sides the urine was stained with blood, and therefore albuminous. The segregator helped him to a certain extent, though not fully; it showed that there was pus in the right ureter. He removed the kidney and part of the ureter in that case. In the case of pyonephrosis there was pus on the right side which soon blocked the catheter. On the left side the urine was nearly clear. It seemed very difficult to get the bladder perfectly clean when pus had been discharged for some time by the bladder. Although the segregator was of great value in obtaining urine which came from each ureter, yet he did not think they would get urine absolutely clear from a healthy kidney.

The **President** regarded the segregator as of great value in diagnosis, and by its use he had avoided doing operations on several occasions which would have been disastrous. In one case a woman had a large painful kidney on the right side, but by use of the segregator it was found that all the urine came from that side. The segregator required to be used with great care, as the results were sometimes doubtful.

Mr. **Bowreman Jessett** said he thought the first case was of great interest. There was no doubt that a diagnosis between a distended gall-bladder, an enlarged kidney, and a carcinoma of the hepatic curvature of the colon was difficult. In one case where he expected to find a large kidney or possibly a hydronephrosis, it proved to be a distended gall-bladder, and on several occasions where he operated for a supposed gall-bladder he had found a large kidney. He would like to ask Dr. Taylor whether in this first case of his the tumour moved on respiration or not? He thought that that was one of the most important symptoms in diagnosing between the kidney and the liver. During deep respiration a distended gall-bladder would, as a rule, ascend and descend, whereas a pyonephrosis would not, but a carcinoma of the hepatic flexure of the colon would often move in the same way as the gall-bladder.

Dr. **Edge** employed various kinds of segregators, and on one occasion, when he used Luy's instrument, found the right kidney extensively diseased, while the urine from the kidney was normal, yet the urine in bladder was practically solid with albumin. The right kidney was removed and the patient made an excellent recovery.

Mr. **Ryall** said these cases were of great interest in reference to catheterisation. As far as he was aware no cases had been recorded where tubercular infection followed the use of a ureteral catheter.

Professor **Taylor**, in reply, said he was gratified by the remarks which had been made, and especially those referring to the use of the segregator. In the particular case referred to the tumour did move on respiration, mainly, he believed, because the colon was inseparably bound up with it. In cases where there was any doubt between gall-bladder and kidney, if they could fix the kidney with the left hand on the loin and move the upper part of the tumour from side to side on the kidney, they might be sure that it was not a kidney tumour. He used Luy's segregator in these cases. In the case of pyonephrosis, there was one large kidney tumour on the right side full of pus; he used the segregator, after washing out the bladder first. Though there was a great difference between the two specimens of urine, yet the urine on the left side was not free from albumin. This might have been considered a sufficient reason for not operating, but from the character of the tumour, and former experience, he knew the right kidney could be of no use because it contained a quantity of pus. Though the other kidney was not healthy, yet he did not remove it, and yet the patient was now well. This was a point with regard to the use of the segregator as distinct from the evidence afforded by catheterisation of the ureter itself.

Dr. **Bedford Fenwick** showed a specimen of

EARLY PREGNANCY IN A FIBROID UTERUS.

and read the following notes:—The patient from whom this specimen was removed was æt. 40, had been married seventeen years, and never pregnant. The periods began at fifteen, had always been regular, lasting three to four days, and the loss normal. The last period was from July 23rd to 26th of present year, so that when I saw her on October 25th they had been absent for three months, and she had increasing pain in the pelvis ever since. She suffered from constipation for the last three years, increasing frequency of micturition and occasional dysuria. The swelling of the abdomen was noticed by her, quite accidentally, only four months ago. There was a little secretion in the left breast, a little moisture of the areolæ, the cervix was full and soft, the vagina slightly violet in colour. The pelvis was completely filled by a densely hard mass, which extended upwards to the level of the umbilicus. The diagnosis was early pregnancy in a fibroid uterus. I performed hysterectomy. The right ovary was a cyst containing about a pint of thick, black blood, and densely adherent to the growth; the left ovary was large and cystic and was also removed. The tumour was moulded into the pelvis and was raised with some difficulty, dense adhesions existing between its under surface, the rectum, and the floor of the pelvis, so that on removal there was a large raw surface, which I covered over with a specially large flap taken from the anterior wall of the tumour. It will be observed that the uterus contains a number of densely hard fibroid outgrowths, and in the uterine cavity is a fœtus of about three months, with sac complete. Below the uterine cavity, above it, and all round, are dense masses of fibroid tissue, forming an almost stony cavern surrounding the fœtus, which must have prevented its further growth and expulsion, so that the operation was performed just in time to save the patient considerable trouble. There is no active degeneration in the fibroid tissue, and I would, therefore, like to call special attention to the density of the more or less recent adhesions formed in the pelvis, and which I imagine were largely due to the increased vascularity caused by the pregnancy, and consequent inflammatory changes at the point of greatest pressure.

Dr. **William Duncan** thought that the specimen was an interesting one, and referred to a case he had eight or ten years ago which was published at the time. He was asked to see a lady who had been married only three months and was suffering from retention of urine. It was found she had a fibroid filling the pelvis and extending up into the abdomen, and that she was two months pregnant. Instead of performing hysterectomy, as he would have done now, and what had been done in the specimen now shown, he emptied the uterus with great difficulty. After the operation the pelvic tumour grew rapidly, and it was quite impossible for the patient to pass any water naturally. Therefore he was obliged to do a hysterectomy soon after emptying the uterus. He was glad to say that the patient did well.

Mr. **Bowreman Jessett** said the specimen was most interesting. It was interesting to know whether the fibroids were present before pregnancy. The probability is that they were present, while pregnancy caused an increased supply of blood to the uterus, thus rapidly increasing the growth of the fibroid which constricted the fœtus and killed it. The question had been raised whether it was wise to empty the uterus in these cases. It was decidedly dangerous, as there might be dangerous hæmorrhage afterwards. In all these cases the better plan was to do an abdominal hysterectomy.

Dr. **Edge** remarked that in his experience it was not so much a question of hæmorrhage as of sepsis. He had seen several cases of long-continued sepsis after miscarriage in fibroid uteri. In his opinion the increased vascularity in the pregnancy would tend to cause absorption of adhesions.

Dr. **Fenwick**, in reply, said that in such cases it was always a question whether delivery could occur by the natural passage, but in this particular case he found that he could not readily get the probe into the cavity. The object of hysterectomy was either to avoid hæmorrhage or sepsis. On the other hand, the hyperæmia associated with pregnancy of three months' duration would cause such an increase in a solid growth as there had been in this case.

Dr. **Duncan** showed a uterus removed by

PORRO-CÆSAREAN SECTION FOR CONTRACTED PELVIS

that he had quite recently performed. The patient was a dwarf, and had very marked hip disease, so that there was very extensive contraction of the pelvis. On opening the uterus the placenta was in front. He cut straight through it and got to the child, and brought it out. Having delivered the child, what was the best thing to do with the uterus? Should it be sewn up and the woman sterilised by removing the patient's Fallopian tubes, or would it be best simply to try, as some recommended, a simple Cæsarean, leaving the tubes alone, and let the woman have repeated pregnancies and repeated Cæsarean sections? His own feeling was that one ought not to subject a woman to the risk of repeated Cæsarean sections, and that the safest operation was, after removing the child, to take up the uterus and do a sub-peritoneal hysterectomy, which in such cases ought to be practically without risk or with the very slightest risk possible. He performed sub-peritoneal hysterectomy in the usual manner. In a pregnant uterus there was not any difficulty in stripping down the flaps of the peritoneum. If the placenta had been posteriorly instead of in front he did not think the patient would have lost more than a couple of ounces of blood; as, in doing hysterectomy, he always ligatured the broad ligament first and then the uterine arteries before attempting to strip down the flaps or cut the uterus across. He did not suppose that the woman lost more than half a pint of blood, nor more than in an ordinary confinement. The operation presented no difficulties whatsoever, and he thought the woman would do well. In olden time when an operation of the kind was done the stump of the uterus was brought outside the abdomen, but now he thought that the safer and much more scientific method was to tie the uterine vessels and let the stump be brought in and closed over with the peritoneum. The patient was about twenty-five years of age.

Dr. **Heywood Smith** remarked that Dr. Duncan did not tell them whether the child was alive.

Dr. **Duncan** said the child was quite lusty, but he could not make out what the sex was. The woman's confinement was due about the 13th instant.

Dr. **Smallwood Savage** read a paper on Hæmatoma of the Ovary and its Pathological Connection with the Ripening and Retrogression of the Graafian Follicle. Illustrated by lantern slides. (We hope to be able to devote space to this paper in our next issue.)

The discussion was postponed to the next meeting.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Medicine.

Meeting held Friday, Nov. 10th, 1905.
James Little, M.D., in the Chair.

SOLUBILITY AS APPLIED TO URINE; AND THE THEORY OF GOUT.

Dr. **Walter Smith** made a communication upon the above subjects. He said:—There are two kinds of molecules in urine—(*a*) non-ionised, represented in normal urine chiefly by urea and kreatinin; in pathological urines, by sugars and proteids; (*b*) ionised—*i.e.*, dissociated molecules—viz., the ordinary salts of the urine. Attention was drawn to the rules for solubility of the classes of urinary salts, chlorides, phosphates, &c., and the bearing of these rules upon clinical phenomena. In respect to the uric acid theory of gout, the writer entirely associates himself with those who feel convinced that this popular theory is inadequate, and, what is worse, misleading in practice. Uric acid, *quo ad* physiology and pathology, never behaves otherwise than as a *monobasic* acid. According to the careful researches of His and Paul the solubility of uric acid in water at 18° C. is 1 in 40,000—a much lower estimate than that usually accepted. Dr. Smith pleaded for a wider and more catholic conception of gout than that popularly adopted. We are still ignorant of the true pathology of gout, and, in respect of dietetics, when we enjoin our patients to take freely such foods as milk, cream and cheese, which are almost free from purin bodies, and to be sparing of food which contains a large amount of purin bodies—*e.g.*, meats, thymus, and pancreas—we embody almost all there is to be said.

Dr. LITTLE, in discussing the paper, referred to the belief in the uric acid theory of gout so firmly fixed in the lay mind.

Dr. TRAVERS SMITH said it was hard to reconcile some obscure alimentary toxin as the cause of gout with the hereditary character often shown by the disease, and with the fact that gout in females is rare till after the menopause, though there were the same dietetic errors before as after.

Dr. BENNETT also spoke.

NOTES ON A YEAR'S ASYLUM WORK.

Dr. W. R. DAWSON read a paper on the above subject. He dwelt chiefly on hereditary predisposition, which he believed to be greater than the usually accepted average, on cases of dementia precox, and on the atropine treatment for alcoholism.

The paper was discussed by Drs. Travers Smith and Kirkpatrick.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT THE UNIVERSITY, SHEFFIELD, ON FRIDAY, NOVEMBER 17TH.

DR. D. LLOYD ROBERTS, President, in the Chair.

THE USE OF RUBBER GLOVES IN ABDOMINAL SURGERY.

DR. T. B. GRIMSDALE, Liverpool, showed composite charts of the pulse and temperature during a few days before and the week after operation in 120 cases of abdominal section. In 40 cases antiseptics were used, in another series of 40 cases aseptic precautions were employed, but no antiseptics were used during the operation, and in a third series of 40 cases rubber gloves were used in addition to the usual aseptic precautions. In the pulse chart the "antiseptic" curve was less satisfactory than the "aseptic" curve, the "glove" curve being the best and returning to the normal about 24 hours before the other two curves. In view of the importance of the pulse curve as an indication of morbidity after operations this was regarded as strong evidence in favour of the use of gloves. In the temperature chart also the "glove" curve was superior to the "aseptic" curve in some respects, and both were markedly in advance of the "antiseptic" curve.

ADHESIONS AFTER CÆSAREAN SECTION.

Dr. R. FAVELL (Sheffield), after mentioning a Cæsarean section done for acquired stenosis of the vagina, described one done for the second time on the same patient, in which considerable adhesions were found between the abdominal wall and the uterine surface.

Dr. A. W. W. LEA (Manchester) had been obliged to open the abdomen on account of persistent pain following a Cæsarean section done by another member of the Society. There were dense adhesions in the pelvis, and after separating these it was found impossible to save the uterus, which was therefore removed. In discussion some of the speakers thought that adhesions between the uterus and the abdominal wound implied some degree of septic infection, while others thought that the irritation caused by the use of antiseptics during operation was sufficient to cause adhesion. Reference was made to the idea that in a second Cæsarean section, owing to the presence of adhesions it might be possible to open the uterus without opening the peritoneal cavity. This was considered to be a very unusual occurrence. An undoubted example of ovarian pregnancy was described by Dr. T. B. Grimsdale.

Dr. J. E. GEMMELL (Liverpool) showed a large mass of fibro-myomata removed, together with a uterus containing an ovum of a few weeks' growth.

Dr. R. FAVELL showed a myomatous uterus removed with the appendages by the abdominal route. The ovaries contained between cysts and there was a large vesicular mole in the uterine cavity.

Dr. J. W. MARTIN (Sheffield) showed a myeloid sarcoma of the uterus, also a large fibro-myoma which had undergone axial rotation, causing cystic degeneration.

Dr. W. E. FOTHERGILL (Manchester) showed a calcified fœtus removed from the abdomen seven years after the occurrence of an ectopic pregnancy which advanced for five months.

LARYNGOLOGICAL SOCIETY OF LONDON.

THE first meeting of the winter session was held at the Society's rooms, Hanover Square, on November 3rd, the President, Mr. Charters Symonds, in the chair. Several gentlemen were nominated for election at the next meeting on December 1st, and some interesting cases were shown by Dr. Dundas Grant, Dr. Donelan, Dr. Scanes Spicer, Dr. Kelson, Dr. Furniss Potter, Sir Felix Semon, and Mr. De Santi.

LIVERPOOL MEDICAL INSTITUTION.

THE first meeting of the Session was held on Thursday, November 16th, Sir James Barr, the President, being in the chair.

A hearty vote of congratulation was accorded the President, in view of the honour recently conferred upon him.

Sir JAMES BARR then delivered his Inaugural Address, taking as his subject the Treatment of Arterio-Sclerosis.

There was an exceptionally large attendance of members, and at the conclusion of the address a vote of thanks to the President was proposed by Dr. Frederick Roberts and seconded by Mr. Reginald Harrison, both of whom had been elected at this meeting honorary members of the Society.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, November 19th, 1905.

THE THERAPEUTICS OF SCOPOLEINE.

SCOPOLEINE is the alkaloid of Scopolia Japonica, and was first noticed in the plant by Langgard. In 1890, Schmidt extracted it and believed that it was identical with hyoscine, but later became convinced that scopoleine differed essentially from the hyoscine known as commercial or German hyoscine. Scopoleine produces an elevation of the intra-vascular pressure by exciting the vaso-motor centre. It exercises no appreciable influence on the respiration or on the voluntary muscles. On the other hand, it diminishes the secretion of the saliva and sweating. It also diminishes cerebral excitability; it acts as an anodyne and a narcotic. Its sedative action is very manifest when given in excitable mania, at the dose of a quarter to one milligramme.

The drug, administered for some time, loses its effect. It is counter-indicated in persons suffering from Bright's disease, in old people, and cachectic patients.

Scopoleine produces mydriasis and paralysis of accommodation. Its mydriatic action is four times more powerful than that of atropine. According to Rosistlay, the narcotic effect of scopoleine on the brain is very prompt; it becomes manifest in four or five minutes. The sleep provoked is irresistible and with delirium.

As a sedative, Bela, of Pesth, attached to a lunatic asylum, made experiments with scopoleine, and found that when it was administered subcutaneously at the dose of half to two milligrammes, it produced constantly *sedative* effects, but not absolutely hypnotic effects.

Lately, scopoleine has been particularly studied as a general anæsthetic, and in the hands of Professor Terrier it gave very satisfactory results. It is administered hypodermically, and a certain quantity of morphia is added to the solution, as an antidote of scopoleine, thus rendering its use inoffensive.

The formula Professor Terrier employs is as follows:

Hydrobromide of scopoleine, 1 milligr.
Hydrochlorate of morphia, 1 centigr.
Distilled water, 1 gramme.

For one injection.

Three or four of these injections, at an hour's interval between each, are necessary to produce sound general anæsthesia. The sleep is profound, permitting the most painful operation to be made. In certain cases, however, as in laparotomy, Professor Terrier employs chloroform as well as the above narcotic. By this method, vomiting and the painful awakening are avoided; the quantity of chloroform is diminished, and the phase of excitability of the commencement of anæsthesia is suppressed. When this mixed anæsthesia is employed only one injection of scopoleine is made, and one hour before the operation.

Ether should never be given to continue the anæsthesia of chloroform, as its vaso-dilating action added to that of the scopoleine would increase the chances of pulmonary congestion or of acute œdema of the lung.

The therapeutic doses of scopoleine may be resumed as follows:—(1) As a sedative in mental excitability, ½ to 1 milligr. (2) As an oculistic agent, a collyre of 0.2 per cent. (3) As a general anæsthetic, 1 milligr., associated with one centigramme of morphia, in injections repeated three or four times at an hour's interval. Consequently, the first injection should be given four hours before the operation. (4) Employed in mixed anæsthesia, one injection one hour before the operation, and chloroform to continue the anæsthesia before beginning the operation.

Lumbago.

From a clinical point of view, lumbago presents two varieties, the neuralgic and the myalgic forms. For the former, the following wafers may be given two or three times a day:—

Phenacetine, iv.
Acetanilide, 1 gr.
Antipyrine, vi.
Salophene, v.
Bromide of K., iv.

In gouty arthritic patients, salicylate of lithine may take the place of antipyrine.

Pyramidon at the dose of 5 grs. three times daily is particularly useful in the myalgic form, or aspirine in 10 gr. doses three or four times a day.

No matter what form may be diagnosed, 10 grs. of hydrochlorate of quinine should be given morning and evening.

As local treatment:—

Salicylate of soda, 2 drachms.
Antipyrine, 1 drachm.
Menthol, 15 grs.
Lanoline, ½ oz.
Vaseline, ½ oz.

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, November 18th, 1905.

At the meeting of the Society for Innere Medizin Hr. Kraus spoke on

Constitutional Cardiac Weakness.

He understood by constitutional weakness a correlative retardation of growth, a vegetation anomaly. So also constitutional cardiac weakness was an anomaly of growth of the heart and uvula, a disturbed growth in correlation to the normal heart. The habitus in which the constitutional weakness was found had been known from the earliest time; it had been described by Aretaeus as the narrow-chested habit. Although pronounced forms attracted the eye and were easily recognised, there were border cases that were by no means easily recognised as such. Individuals so affected were found serving as models to painters and sculptors, they were serving in the Guards, and they were even sent on service to South-West Africa. The habit was mostly known as a predisposing factor, but it had no relation to any special disease. It depended on a certain philogenetic malformation of the thorax, and was characterised by two factors—(1) narrowness of the thorax; and (2) an abnormal length of the lumbar vertebræ. By these the symptoms were explained. There was smallness of upper and lower apertures of the body and from these change in the form of the liver and displacement of the kidneys, perpendicular position of the stomach, deeply lying pelvic floor, curvature of the spine, "lymphatismus," nervousness in the varied forms of neurasthenia. In marked cases the heart was absolutely small. The heart too small was insufficient, and thence tachycardia, inability for severe bodily exercises, mitral murmur of insufficiency from relaxed tone of the cardiac muscles.

At the Gesellschaft der Aerzte Hr. Kraus discussed the

Mechanism of Free Pleural Effusions.

Before Rauchfuss in 1904 drew attention to the significance of the paravertebral triangle the question of the mechanism of free pleural effusions had been discussed. By this term "triangle" was understood a constant triangular dulness, in all exudative pleurisies, with every kind of percussion demonstrable on the sound side and often reaching to the upper margin of the exudate. Its height was parallel to the extent of the exudation, and it therefore allowed practical conclusions as to the varying extent of the exudation to be drawn. The triangle was most markedly pronounced with right-sided effusions. It was always found in exudative pleurisy, pleuro-pneumonia, pericarditic effusions, but it was not present in pure pneumonia. The physical conditions of its appearance were studied by Rauchfuss on the cadaver, further, on living children and by the speaker pathologico-anatomically, both clinically and by experiment on dogs. It was shown thereby that the œsophagus was only slightly displaced, but that the anterior mediastinum on the other hand was markedly pushed aside. The heart as such did not influence the size of the triangle so much.

The distribution of the fluid of the pleural effusion was commensurate with (1) the weight, but only in the case of pneumo thorax; (2) fibrinous adhesions; (3) the movements of the lungs. The distribution of smaller effusion was dependent on gravity. The movement of the lung determined the very first distribution, then the weight of the effusion. The upper margin of the effusion was never concave, but was parabolic mostly in left-sided effusions. (Demonstration by Röntgen illumination.)

Hr. de la Camp spoke on

Tuberculosis of the Mediastinal and Bronchial Glands.

His work was founded on the study of the disease in 1,200 children. The physical diagnosis was more difficult, Röntgen illumination was frequently not sufficient, whilst the Platten process gave beautiful images. Rachitic change at the point of union of bone and cartilage led to mistakes being made.

Cough was a very important symptom of gland tuberculosis.

Hr. Stegrer then gave a note on

The Position and Form of the Stomach.

He studied the position and form of the stomach by means of X-ray shadowgraphs, partly, indeed, by bismuth. Peristalsis was reduced by opium. He found that the stomach assumed a fairly vertical position, and showed an extended and occasionally an hour-glass form. The diagnosis of enteroptosis was frequently incorrect, as the stomach often reached to below the umbilicus.

On the objections of Hr. Lessing that he had never found this condition at operation, Hr. Kraus observed that on opening the abdomen other conditions were present.

At the meeting of the Medical Society Hr. Schuster showed a man, æt. 60, suffering from

Alexia.

The condition had been present for a year and was at first associated with right hemiplegia. The patient could speak and had a complete understanding of words, he could cypher and knew his letters, but he could not frame them into words. There was slight narrowing of the field of vision. The associative connection between vision and the speech centre was destroyed. The seat of the disturbance was generally taken to be the angular gyrus, the termination of the left lower temporal convolution through which fibres from both centres of vision ran forwards, those of the right after previous crossing, those of the left uncrossed. A special centre for word formation, and thus a centre for reading had been often denied. For the occurrence of alexia it was necessary that the left centre of vision should be excluded, that there should be right hemianopsia, and that the communication from the right centre of vision to the centre for speech should be interrupted. Alexia was therefore a quite distinct form of some blindness (Seelenblindheit). The communicating fibres from the optic to the acoustic centre ran in bundles. There was an alexia without hemianopsia.

Hr. Mendel called to mind a case of his own, shown in 1902, with right hemianopsia. The patient died a year later. The autopsy revealed softened patches, one in the gyrus fusiformis and lingualis of the left posterior convolution, and one in the splenium corporis callosi. The first explained the right hemianopsia, the second had destroyed the communication between the right optic centre and that of speech. Both patches of softening arose from blocking of the posterior cerebral artery.

As the communication from the left optic centre (therefore right field of vision) to the speech centre was shorter and more direct than from the right, it agrees more with the physiological aspect of the matter that we read from left to right and not the other way about as the Hebrews did.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, November 18th, 1905.

SUCTIONAL ACTION OF CAPILLARIES.

At the "Naturforscher und Aertze" meeting, Cöln contributed an article on the power of capillaries in the propulsion of blood. This subject has long been disputed, and has divided investigators into two schools. Cöln is a disciple of Bier, who affirms that this property belongs to capillaries, and gives an example of tying the arm with an elastic tourniquet, leaving the tissues pale and bloodless. When the ligature is removed, the blood rushes into the capillaries causing the arm to become red. Again, if the arm be made cyanotic before the tourniquet is applied, the blood will not rush into the tissue as in the first case. Bier carried out these experiments on pigs with satisfaction to himself, but failed to convince his co-workers on the subject, although he was satisfied that some absorption or attraction existed in the tissue. From this opinion it is evident that the cause must be looked for in the capillaries. Stricker gave it as his opinion that the capillary distended and that its walls became thinner, although the vessel was flattened by the cells. Owing to this action, he considered that the principle of suction was induced in the capillaries. Matthes commenced experiments on the dead body in order to show the influence of the heart and muscular properties of the arteries, which he afterwards endeavoured to eliminate in order to support Stricker's theory. In all his experiments he found two-thirds of the cases contained blood in the arteries and had a positive pressure of 15 ctms. of water. In the remaining third of cases the vessels were almost empty, with a negative pressure of half a centimetre to four centimetres, while the veins in both cases had a positive pressure. This emptying of the arteries could not be explained on any other principle than a suctional movement in the periphery. Experiments in life by tying the arm with Riva-Rocci apparatus tend to prove the same fact and confirm the theory that some active principle is present in the capillary tissue. Herz said that the results of onychographia went to show that greater pulsations were observed after an arterial hyperæmia, and that they were reduced after venous hyperæmia, but it must be considered that there is an impediment to the movement of blood long after the hyperæmia is relieved. This condition is also present where there is cramp or paresis of non-muscular vessels.

Hering expressed dissatisfaction with the results, as he found it always difficult in his experiments to determine the action of capillaries and arteries, as he did not believe that arteries existed without muscles.

CARDIAC TRAUMATIC INJURY.

In continuing the discussion of this subject of heart affection, Pietrzikowski affirmed that these lesions were on the increase as shown by the accident insurance companies, which is an additional verification of medical investigation. The Bohemian Accident Insurance Company had in the year 1891, 409,000 insured against accident with 2,068 accidents to the cardia. Last year the same company had a million insured with 15,555 accidents to the heart. It is difficult to conceive how these numbers have increased in so short a time. Such rapid changes deserve serious consideration. He thought Frank's theory of the cause should be accepted, such as crushing of the cardiac muscle, myomalacia, and insufficiency. Another important cause in the production of this accident should not be overlooked, viz., cardiac neurosis.

The prognosis of such cases must be guided by the existing phenomena succeeding the accident and the functional damage after recovery, which will be at least 50 per cent. In a future insurance our judgment must be guided by the preceding history, as a recurrence is likely to take place after psychical stimuli or over-exertion.

Jaroschy considered that there was a connection between these accidents and disease, and was inclined to believe that the latter, such as articular rheumatism, was a common cause. It is well known to accident insurance companies both public and private that these accidents are on the increase, and more difficult to deal with in spite of all our medicine and surgery. Although we may speculate on the different causes, we are still left to pass judgment on the amount of damage done to the heart, at the same time protecting companies from fraud, while satisfying the righteous demands of the insured.

Operating Theatres.

ST. BARTHOLOMEW'S HOSPITAL.

OPERATION FOR DUCT PAPILLOMA OF THE MAMMARY GLAND.—Mr. McADAM ECCLES operated on a woman, æt. 43, who had been admitted with a small swelling in the left breast, and a history of a blood-stained discharge from the nipple. This history made the diagnosis fairly certain as that of so-called duct papilloma. Mr. Eccles remarked that the best method of dealing with such a case was to carefully split the nipple into two exact halves and then to trace the growth to its final limit. This was done, and on the surface of one-half of the nipple among the exposed ducts one was seen to differ from all the others; it was dilated, bluish in colour and evidently had both fluid and solid contents. Gentle pressure upon the surface of the dilated tube caused a blood-stained discharge to exude from the orifice on the half-nipple. Mr. Eccles then proceeded to carefully trace down the affected duct to its connection with the corresponding lobule of the breast. The whole length appeared dilated, and it was not until a depth of an inch and a half had been reached that the whole of the diseased part had been separated; this portion was then completely cut away. All hæmorrhage having been arrested, the two portions of breast tissue and the two halves of the nipple were approximated by four silk sutures; two of these, of stronger silk, united the deep parts of the gland and remained buried, while the other pair, of finer silk, accurately brought together the tissue of the nipple itself. Mr. Eccles said that those cases were rare, but of considerable interest both from a pathological and a clinical point of view. The origin of the papillomatous growth was undoubtedly in the epithelium lining the duct itself, and therefore the tumour was somewhat different in its nature from those growths which might be strictly termed adenomata. The latter, he pointed out, were derived from the epithelium of the acini and tended to block the ducts rather than dilate them. It was essential, however, he thought, in treatment, to thoroughly eradicate the whole of the dilated duct and its corresponding portion of mammary tissue; if this were not done a so-called recurrence, he said, was almost certain to follow, because portions of the growth were actually left behind. The disease, he remarked, was innocent in nature, and although the skin occasionally became reddened and adherent, the imprisoned papillomatous growth seldom if ever protruded through it. He further pointed out that the tissue of the nipple healed well and its corrugated surface obliterated the evidence of the scar. Complete removal, in Mr. Eccles' opinion, meant complete cure.

The wound in this case healed rapidly, and no deformity of the nipple was left, the scar which remained being practically invisible.

ITALIAN HOSPITAL.

Wertheim's Operation for Cancer of the Cervix.—Mr. Lenthal Cheatle operated on a woman, æt. 42, who had been admitted suffering from a small squamous epithelioma of the cervix uteri, not spreading to the vagina or involving the uterus. The case had first been admitted under Dr. Vincent Dickinson, and then handed over to Mr. Lenthal Cheatle for operation. Dr. Dickinson had not found any broad ligament affection, nor could any complications be discovered by examination of the abdomen. It was decided to operate by the abdominal route, and Wertheim's operation was performed as follows:—The urine was drawn off by catheter, and the patient placed in the Trendelenburg position; after the whole of the abdomen and the upper part of the thighs had been purified, an incision was made in the middle line between the symphysis pubis and the umbilicus. The posterior layer of the broad ligament was divided on each side, and the ureters were exposed as far as their entrance into the parametrium; the bladder was then separated from the uterus. This was followed by ligation and division of the infundibulo-pelvic, broad and round ligaments on both sides. The uterine arteries were next ligatured, and the portions of the ureters leading to the bladder were isolated by digital manipulation. The posterior layer of the peritoneum was then divided, and the rectum separated from the vagina, which last having been cut across, the uterus, with the appendages, was removed. For the extirpation of the enlarged lymphatic glands, the incision in the peritoneum was carried upwards, and the great iliac vessels being thus more fully exposed, masses of enlarged lymphatic glands in the regions of these vessels were removed, those on the right side being greater than those on the left. The resulting cavity was loosely filled with iodoform gauze, the ends of which protruded from the vagina; the peritoneum was sewn over this gauze and the abdominal wound closed in the usual way, no drainage tube being employed. Mr. Cheatle said that the main lesson this case taught was that it was impossible to remove cancer efficiently by any operation conducted through the vagina; however small the cancer, he did not consider it safe to attempt its removal by the vaginal route, for by this route the lymphatic glands which he had removed in the present operation would have been inaccessible; therefore the only safe course to adopt was a complete operation, such as that described by Wertheim. The cervix and all the glands were subsequently microscopically examined; the cervix and lymphatic glands on the right side were filled with squamous epithelium; those on the left side, although enlarged, did not contain any malignant growth; their enlargement was due to a great increase in the amount of the pre-existing endothelial cells.

The patient did well, and a week after operation was convalescent.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 22, 1905.

VIAVI IN SOUTH AFRICA.

In the matter of the control of quack practice some of our dependencies certainly appear to have the advantage over their mother country. That, at least, is the conclusion that suggests itself upon reading an account of a recent prosecution in Pretoria. Our authority is the *South African Medical Record*, which, in its October number, comments freely upon the prosecution of the manageress of the notorious Viavi Remedy Company. There were three charges under the Transvaal law which, it should be remarked, differs from the Cape and Natal laws regulating medical practice. There were three specific charges—first, one of practising as a medical practitioner; secondly, of practising as a chemist and druggist; and thirdly, of performing acts specially belonging to the calling of a medical practitioner and a chemist and druggist, by prescribing for, and selling to, certain persons mentioned in the summons certain remedies. On the first charge the Resident Magistrate found the prisoner not guilty, basing his opinion on a decision of the Cape Supreme Court, that "practising" is the receipt of payment for services rendered. In that particular case there was no proof that anything but the medicines had been charged for. The second charge he also dismissed, on the ground that the remedies were sold in packages without any compounding. On the third charge he convicted, and incidentally gave the following lucid view of the question :—"I do not," he said, "consider it necessary to touch or feel a patient in order to call it an examination. I think the mere fact of listening to a patient describing his symptoms, and putting one or more questions to him in connection with the subject, may be considered an examination. Then follows the diagnosing, resulting in the immediate supply of the necessary remedies, which in this case were all in payment." On the second part of the third charge he found the accused not guilty, chiefly because he held that the supplying of medicines was part of the art of prescribing, and that accused was therefore on the same footing as a medical man who dispenses his own medicines. The saving clause in this excellent judgment is the particular clause in the Transvaal Ordinance, which couples with the "practising" the performance of "acts specially belonging to a medical practitioner." The view taken by the Pretoria magistrate is that indirect payment constitutes "practising," that is, money handed over for remedies and not directly for medical advice. If that view be sustained in the higher Transvaal Courts, then it will place that jurisdiction upon a far better basis than that of any other part of South Africa, so far as the control of irregular medical practice is concerned. Nay, more, it may well excite the envy of reformers in the United Kingdom, who stand helpless in the face of unrestricted quack practice of every conceivable kind. British law, in fact, seems to be framed with a view of giving a free hand to quacks and charlatans. There is not one of them who, with ordinary intelligence, may not amass a fortune and set the law at defiance. Yet a few simple clauses inserted into a Medical Act would extend to us the protection that the burghers of the Transvaal enjoy. Here in London we read from day to day of a "medical specialist" appearing in the criminal courts with the assumed title of "doctor." For years past he has conducted a large irregular practice, professing to deal with diseases of the urinary and every other system of the human body. The thing is a scandal, and it is a standing reproach to the General Medical Council that they have done nothing to protect either the public or the medical profession against such gross abuses. As regards the Viavi remedies, their worthlessness has been repeatedly demonstrated in these columns, and for years past our vigorous contemporary, *Truth*, has castigated the undertaking as a heartless fraud. At the bottom of the whole unsavoury business lies the greed of newspaper proprietors, without whose advertisement columns these cruel vampires could not exist for a day. Yet apparently respectable journals still publish advertisements of "Bile Beans," the description of which was recently described by a British judge as a lying swindle. Then, again, in spite of the clearest scientific evidence that Liquozone killed a child by its irritant action when administered as a medicine its advertisements are nevertheless still accepted by many editors. The power of the public press is omnipotent to stop this deadly social canker if the newspaper proprietors would but unite to suppress the evil. But the medical profession is to blame, inasmuch as it has endured for so long the supineness of a non-representative General Medical Council, and the feebleness of anomalous and defective medical Acts that defend neither themselves nor the public.

INSANITY—A GROUND FOR DIVORCE.

From time to time attention is drawn to the unhappy state of the party to a marriage whose husband or wife, as the case may be, is insane, and the question is pertinently asked whether such a person is not morally entitled to a divorce. The fact falls within the scope of the everyday observation of medical men, and the hardship of the lot of one partner to a marriage who is denied the privileges and comforts of a contract through the insanity of the other cannot but forcibly be borne in on them. No one, we fancy, would suggest that the simple fact of insanity *per se* should be regarded as sufficient to invalidate the marriage contract, but there are collateral circumstances, and groups of circumstances, which occur with comparative frequency, and are of sufficient force to make the question one to be fully and fairly debated with a view to alteration of the law. Most thinking people would regard with abhorrence any such laxity in our own marriage laws as that which obtains in America, and would rather revert to the condition of things that prevailed before the institution of the Divorce Court than see marriages made and broken with the prodigal facility granted by many of the states of the Union. The sanctity of marriage is a cardinal tenet with the Christian churches, and the influence of that belief has been a potent agent in securing and maintaining the stability of civilised society; as such it is to be treated with the greatest respect and consideration. On the other hand, the institution of marriage was ordained for certain utilitarian purposes, and if these purposes cannot be subserved, it is at least arguable whether it is not more rational to allow a revision of the contract than to push its interpretation to an extreme that brings the institution into disrepute or ill-favour. The principle of insanity, acting as a ground for the dissolution of a marriage, is already admitted by law, for if it can be shown that a person was a lunatic at the time of entering into the contract, the marriage may be annulled by the Court. But in this case everything turns on the degree of insanity present, Sir James Hannen having laid it down that it was necessary to prove that the lunatic did not possess the capacity of understanding the nature of the contract and the duties and responsibilities it created ; but as, he further remarked, he did not think that a large degree of intelligence was needed for this purpose, it is not surprising that very cogent and emphatic evidence is required before a judge is prepared to declare a marriage null. It is hardly conceivable that anyone would marry a lunatic with so small an amount of reason as not to be able to comprehend what marriage was and what it entailed, that is, unless the sane party was thoroughly well aware of the mental condition of his partner, and was acting from unworthy motives of self-interest, financial or social. The class for which the strongest case for some alteration in the law can be made out is that in which information as to previous insanity in one of the parties is deliberately withheld from the other, with a view to relieving a family of an inconvenient incubus. This applies especially to instances in which there is ground for the belief that the attack of insanity was not a mild one due to some temporary circumstance, but the prelude to a more or less constant condition of mental aberration. A marriage procured under such circumstances is obviously procured by deceit, and it is not only bad for the State as likely to produce a family of mental weaklings, but the action of the instigating parties is obviously *contra bonos mores*. In an ordinary civil contract the suppression of a material fact before signature is sufficient to invalidate the agreement, and it is difficult to see why the same principle should not apply to marriage, especially now that in the eye of society it has lost its significance as a religious sacrament and assumed a purely civil character. It seems to us that it is no proper defence to aver that it was the duty of the party aggrieved to have informed himself before marriage of all the previous history of the other person ; the suitor before marriage will naturally rely on the trustworthiness of the witnesses from whom such information can be obtained, either directly or by implication—namely, the relations of the other party. Nor should it be necessary for the Court, as in nullity suits at present, to require incontrovertible evidence of absolute incapacity to realise the responsibility of marriage before it can act ; for every reason, private and public, the whole mental history of a person before marriage should be available to the other party. Again, it may well be asked whether chronic and incurable insanity in a husband or wife, even though it may have developed since marriage, should not, after a sufficient interval and with due safeguards as to maintenance and so forth, be regarded as good ground for divorce. In the case of mental disease, the ordinary arguments that pertain in the case of physical illness do not apply, for the insane person is separated from his family, and therefore cannot be held to need the comfort and protection of their society. Holding a person bound to a hopeless lunatic whom he can seldom see and never obtain sympathy and support from, is to place a premium on immorality ; and most doctors have probably met with instances of men whose wives were insane, living in open concubinage, to the detriment of the women involved and the scandal of society. From a lucid paper in the *Humanitarian*, by Dr. Forbes Winslow, we learn that fifteen years ago he took the opinion of the Psychological Section of the British Medical Association on these questions, and that the majority of members were in favour of incurable insanity constituting a ground for divorce, and all of them supported the proposition that insanity at the time of marriage and the wilful concealment of the fact of insanity before marriage should be sufficient to nullify a marriage. As matters stand at present, cases of great hardship constantly occur, and the question is ripe for full and careful debate.

Notes on Current Topics.

"Quick Curative" Treatment in Gonorrhœa.

The treatment of gonorrhœa is generally admitted to be unsatisfactory in the primary stage, so unsatisfactory indeed that most medical men adopt the "expectant" method, which if it does no good, at least does no direct harm. Various abortive plans have been tried at one time and another, but the general consensus of opinion is against them. Occasionally they cure, but more often they do not, and not infrequently they do much harm. Still, it would seem likely that sooner or later an abortive treatment of safety and efficacy will be introduced, and it may be that the plan described by Dr. Frederick Lyons, of New York, in the *Medical Record* of November 4th, is the plan of the future. Dr. Lyons has been using his treatment for ten years, and he is even more satisfied with it now than he was after his earlier experiences. In the opinion of Dr. Lyons the important point in the early treatment of gonorrhœa is to attack and kill the gonococci before they have passed through the epithelium of the urethra, and it is to cases in which this event has not happened that his treatment is applicable. To ascertain how far the infection has gone it is necessary to make smear-preparations of the sero-purulent discharge from the urethra when the patient is first seen. If there are a fair proportion of epithelial cells present and these contain gonococci, the treatment is likely to be successful, but if, on the other hand, there is much pus and practically no epithelium, the disease will have gone too far for any abortive method. Dr. Lyons' plan of treatment is to lay the patient on a couch, and quietly to inject from a soft conical rubber-syringe a drachm and a half of a 4 per cent. solution of silver nitrate. Very little pain is produced and the patient can resume his ordinary life, under proper hygienic restrictions. If not entirely successful a 2 per cent. solution may be used later, and even a third injection—this time of a 1 per cent. solution—may be necessary. Dr. Lyons claims to have treated over four hundred cases by this plan, and in 384 of these the disease was rapidly brought to an end. Dr. Lyons is certainly to be felicitated on such results from what he terms the "quick curative" method.

Dilatation in Dysmenorrhœa.

Severe dysmenorrhœa was till lately one of the most disappointing conditions a practitioner could be called upon to treat, but now that dilatation and, if necessary, curetting are available as legitimate modes of treatment many of the worst cases can be markedly relieved. As is generally known, all cases of dysmenorrhœa do not respond to the operation, but on the other hand many patients for whom much was not expected derive marked benefit. The operation is still, therefore, somewhat in the experimental stage, and the experience of medical men who have performed it in a large number of cases is of great interest. A paper in *American Medicine* by Dr. Holden, Resident Gynæcologist at the Johns Hopkins Hospital, furnishes such experience, and as his ninety-five cases have been carefully tabulated and classified they deserve careful study. The patients treated all suffered from primary dysmenorrhœa, that is to say, dysmenorrhœa not associated with obvious organic disease of the uterus or its adnexa; to this latter class of case the operation is not applicable. In four cases it subsequently became apparent that inflammatory trouble was present, but the remaining 91 cases had either existed since menstruation began, or followed some acute general illness, such as typhoid fever, or some change in habit or occupation. It is not possible here to give more than a brief summary of Dr. Holden's results, but it may be mentioned that no patient is included in his tables who has not passed at least a year since the operation, and some have been under observation very much longer. In 33 per cent. complete or very great and permanent relief was gained; in 7 per cent. complete or great relief for a year, with subsequent return of the symptoms; in 8 per cent. some relief for a year or more and no relief or very slight temporary relief in 50 per cent. With regard to the general prognosis Dr. Holden finds that the best result is to be anticipated when the pain is paroxysmal in character, when it begins before or at the beginning of the flow, and when it only lasts a day or two.

Doctors and Midwives.

It is no new thing to find midwives preaching the doctrine that the lying-in room is the exclusive sphere of woman, and that the medical man is at best an interloper there. It is urged, over and over again, by ignorant or interested people that there is nothing in the course of ordinary labour requiring the assistance or supervision of a medical man, and that consequently the function of the latter is, to use the common parlance, "to follow the midwife." Of these fallacies our readers are probably weary. It is a new thing, however, to come across such arguments propounded by a member of the medical profession, who presumably ought to know better. Nevertheless, in a paper appearing in one of the nursing journals (*a*) under the signature of "F. Cavanagh, M.B., Ch.B., F.O.S. (Edin.)" we find such remarks as that "in the conduct of an ordinary case there is nothing which could not be done by the average common-sense woman with a few months' training," and that "there is too much wire-drawn distinction between the provinces of nurse and doctor." Moreover, in Dr. Cavanagh's opinion, the medical man should be "retained as consultant, holding himself in readiness to attend if summoned by the nurse." The writer suggests the cultivation of "finger-tip knowledge by vaginal and abdominal examinations" as an essential element of a midwife's training, and argues for the lowering of the standard of training by bringing forward the case of "the colliery districts in the Midlands, where thousands of births occur without a doctor being summoned, under the ægis of so-called 'midwives,' who are unscientific, untrained, and septic to the last degree, and yet succeed in doing comparatively little harm." We presume that the term "comparatively little harm" is meant to cover the deaths from puerperal sepsis, which, in spite of all our knowledge of sepsis and the ways of presenting it, show little or no sign of diminution in numbers. Such teaching as this of Dr. Cavanagh's must be held responsible for its share in the continuance of the present methods, to which in part is due the continued high mortality among parturient women.

Huddersfield Babies.

Our readers will remember our comments last year on Alderman Broadbent's sporting offer to Huddersfield parents when he assumed the Mayoralty of that town. This worthy city-father, with as much insight as benevolence, promised to pay a sovereign to the parents of each baby born in his ward during his year of office, if the child lived to be a year old. It is now reported that 110 infants so born have passed that critical age, and the distribution of rewards is shortly to take place. As to the effect this offer has had on infantile mortality, it is worthy of notice that the death-rate in Alderman Broadbent's ward was only 54 per 1,000 births, as compared with 122 for the whole neighbouring district, 144 for the whole borough of Huddersfield, and 150 for the whole country. It is calculated that no less than 92 babies who otherwise would have been expected to perish are alive and kicking, and may in course of time become 92 praiseworthy citizens of Huddersfield and the

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(*a*) *Nursing Times*, November 11th, 1905.

Empire. Gratifying as such success cannot but be to the promoter of the scheme, the facts as stated are calculated to leave a rather unpleasant taste in the mouth. Has it come to this, that English parents have to be bribed not to let their children die? And is it possible that for twenty-shillings these parents will work for their children, when without reward they would rather have allowed them to perish? While warmly congratulating Alderman Broadbent on his success, we cannot say that our feelings towards the 92 parents is one of ecstatic admiration.

Sanitation in the Hebrides.

Bishop Butler long ago pointed out the tendency in human nature to feel a certain gratification in the reflection on the misfortunes of other people. In this mood our Irish readers may take some comfort in the revelations of the conditions of life in the Hebrides, as detailed in a recent report to the Local Government Board of Scotland. The report shows a state of affairs certainly worse than anything which obtains in the poorest districts of Mayo and Donegal. In the village of Arnol, for instance, in the island of Lewes, there is a population of 347, but with the exception of three stone and mortar houses every house in the village is such as could be certified as a nuisance under the Public Health Act. In all of them, with the exception of the three mentioned, the sitting-room of the house is also a byre and contains cows, fowl, sheep, or a horse. The fire of peat burns in the middle of the floor, and the smoke finds its way through various rough openings in the walls and roof. The floors are of clay, and sodden with manure. The walls themselves are of stone in two rows with earth piled between them. In other villages throughout Lewes a similar condition of affairs exists. These matters call for the serious attention of the local sanitary authorities, and it is probable that the force of example in building healthy cottages would go far to demonstrate to the people the necessity of reform.

Malarial Problems in Panama.

Now that the Government of the United States has taken seriously in hand the construction of the Panama Canal, they find that the greatest feature in the problem before them is, as it was in the case of the French, the hygienic one. The gruesome mortality and sickness among the labourers employed by the French is still fresh in people's minds, and profiting by their predecessors' experience the Americans are preparing to take steps to prevent any repetition of such calamities. From the first report of the chief sanitary officer we learn that malaria is the disease *par excellence* which will have to be fought. From blood-examinations of the natives it has been found that over 60 per cent. actually harbour the plasmodium malariæ in their blood, and it is probable that practically all of them have suffered from the disease at some time or another. This experience is on a par with that of observers in other malarial climates, and in view of modern knowledge, it is a fact that is ominous of trouble to come. It has been shown that dwellers in malarial districts gain, as the result of previous attacks and the long-continued presence of the plasmodium in their blood, a kind of immunity which protects them as a rule from further attacks. But with strangers coming to those districts, the case is far different, and the natives, though immune themselves, are a potent source of infection to newcomers. The task before the sanitary officials, then, is no light one. If they are to import and keep in health many thousands of labourers, it will be necessary either to destroy the parasites in the natives, or to keep the labourers immune by means of quinine or to destroy all the mosquitoes that could act as carriers of infection. The commissioner most wisely recommends that no steps towards the construction of the canal should be taken till all preparations for the reception of the employés have been made, and chief among these preparations, of course, are the sanitary ones. The solution of the malaria problem, in particular, will be watched with sympathetic interest by this country.

Oliver Wendell Holmes and Puerperal Fever.

Though few people on this side of the Atlantic are prepared to admit Oliver Wendell Holmes, as Professor Osler did a few days ago, to the high company of Rabelais and Sir Thomas Browne in regard to literary merit, yet he is owed a debt of gratitude by the human race, of which Dr. Cullingworth does well to remind us in the address delivered recently before a country branch of the British Medical Association. "There was a time," said Holmes himself, "in which I would have said that the best page of my record was that in which I had fought my battle for the poor poisoned woman." Though it is often overshadowed by his great literary reputation, the service done by Holmes in preaching the contagiousness of puerperal fever some years before Semmelweiss put forward the same view in Vienna, is one which should endear him to succeeding generations. It is curious that each of these observers got his suggestion from a similar accident occurring in his experience—the death of a colleague from sepsis. Moreover, the opposition faced by Holmes, if not as bitter in its persecution, was nearly as formidable in its stolidity, and in the ridicule freely used as its weapon, as that which proved fatal to Semmelweiss' professional career. The essay in which Holmes' views were put forward may indeed bear comparison from the merely literary point of view with any of his works. As a piece of cogent reasoning, there is nothing to surpass it in the realm of scientific letters. Line upon line, precept upon precept, Holmes proved his case to conviction, and this, to quote his own words, "before the little army of microbes was marched up to support my position."

Differential Diagnosis of Primary Sore of the Tonsil.

Though a hard chancre in one of the usual situations does not as a rule present much difficulty in diagnosis, yet when it occurs in so rare a site as the tonsil it is natural that some confusion may arise. According to its form or the course it pursues it has been mistaken for such varying conditions as simple tonsillitis, diphtheria, epithelioma, and a tertiary lesion. The confusion with diphtheria and other ulcerating infection is most common, and Krefting, of Christiania, who has reported thirty-six cases of chancre of the tonsil, mentions that many of the patients had been sent to the diphtheria ward. In some cases the sore has been excised as epithelioma; the mistake only being discovered when the specimen was subjected to microscopic examination. Dr. Montgomery, of California, has recently published the report of a peculiar case (*a*) in which a crypt of the tonsil infected with staphylococcus was regarded by many experienced observers as a hard chancre. The crypt was of a peculiar form, deep and funnel-shaped, with a bulged rim, and being half filled with a dirty greyish mass it presented all the appearances of a primary sore. It disappeared, however, without specific treatment, and it was only on its reappearance some years later that its true nature was realised.

Action Against Chloroformist.

An action brought lately in the Scotch courts against a medical man for alleged unskilled chloroform administration has been settled out of Court. The pursuer claimed £1,000 damages for the loss of her husband. On the other side it was contended that death was due to acute nephritis and catarrh of the stomach, followed by syncope. It is somewhat a matter of regret, apart from individual considerations, that the matter was not threshed out in Court. South of the Tweed there is little doubt that the chances of success in such a suit would be infinitesimal. It is only under most exceptional circumstances that the stigma of malpraxis is attached to a medical man in any court of law. The assumption is that he has done his best by his patient, albeit success may not have attended his efforts. To fix responsibility upon a medical attendant there must be such clear evidence of gross negligence or want of skill and proper precaution as to attain a degree of criminal importance. Were this attitude otherwise, the conditions of medical practice would become intolerable. In the case of chloroform administration, for instance, the risks are so intangible, so unforeseen, and yet so real and ever-present that anæsthetists would disappear from the face of the land were they subject to legal actions in case of misadventure. Fortunately, British law takes on the whole an extremely sound common-sense view of the difficulties that everywhere beset the paths of medical practice.

Glass in the Dressing of Wounds.

The art of surgery is truly catholic in its adaptation of materials to its peculiar needs and wants. Almost every conceivable object in nature has been pressed into its service at one time or another, although the current of modern surgery has set in strongly in the direction of simplicity. One of the most interesting recent surgical developments has been the use of glass in the dressing of wounds. This plan has been advocated by Mr. J. L. A. Aymard, M.R.C.S., in the columns of our contemporary, *The Lancet.* The method was first tried at the Johannesburg hospital, where a piece of thick window-glass was ground down at the edges, smeared with carbolic oil, and applied to a wound. The results were satisfactory, inasmuch as the wound healed rapidly and without visible scar. Should further trial support the usefulness of glass as a substitute for ordinary dressings there will be obviously much to be said in its favour, such as considerations of economy, stability, and ready sterilisability. One of the great advantages would be that the transparency of such a plan would permit the surgeon to inspect the state of the wound without disturbing dressings. Mr. Aymard's suggestion is well worth extended trial, especially in hospital practice, where the cost of surgical dressings is necessarily great.

Lincoln and its Typhoid Litigation.

The woes of the ancient City of Lincoln have not come to an end with the cessation of the outbreak of enteric fever that recently played havoc with its prosperity. It is announced that no fewer than seventy-seven actions have been brought against the Corporation for damages arising out of the epidemic. The ground of action is apparently simple. For many years past Lincoln has been warned emphatically and repeatedly by medical officers of health and by Government Board Inspectors as to the polluted state of the local water supply. As a result of that contamination, a great number of townsfolk contracted typhoid fever, and many died. The question naturally arises to what extent the Corporation is responsible for the visitation. The man in the street will probably answer "to the last penny," but it by no means follows that the law-courts will take a similar view. At the same time it should be borne in mind that the trend of legal decisions has of late years pointed in the direction of fixing responsibility upon negligent sanitary authorities. The town authorities would have acted wisely had they adopted our advice, given early in the epidemic, to sterilise the whole of the town supply before distribution by means of a system widely adopted in France. The issue of the present legal conflict will be watched with concern by all who are interested in public health administration, inasmuch as it would be difficult to imagine a clearer test-case relating to corporate sanitary responsibility to individual ratepayers.

(*a*) *The Canadian Pract. and Rev.*, October, 1905.

Members of the Royal College of Surgeons of England.

The annual meeting of the London College of Surgeons was attended by the usual emphatic protest by members against the non-representative government of the College. The principle involved, namely, that of the right of members to have a voice in their own government by the right to vote for Councillors, is hardly open to serious discussion. Indeed, so far as that goes, the present autocratic Council do not attempt to justify their position, but simply ignore or politely shelve the matter from year to year. It is no answer to the charge of being a close corporation to point to a long and illustrious career of usefulness and success. The issue at stake is whether the members of a college have or have not the right to object to their collegiate affairs being managed by a knot of irresponsible autocrats. Mr. Tweedy, the President, argued last week that members' wishes could not be acceded to without a complete alteration of the Charter. Surely, if the Council be agreed upon the justice and wisdom of an extended constitution, adequate powers could be speedily obtained from the Crown. Judged by modern methods of thought, there can be little doubt that the constitution of the College of Surgeons might with advantage be brought more into line with that of other great public institutions.

Football in Schools.

The Blantyre School Board has taken the strong step, so it is reported, of excluding football from the schools under their control. The ground of their action is stated to be the injurious effect upon the health of the lads. They are reported to have obtained medical testimony to the effect that youths who have played football are thereby rendered liable to untimely deaths in later life from heart disease. This conclusion, if it be sustained, has an application far outside and beyond the regions of Blantyre. If football be the fatal pastime maintained by its sapient School Board, then it applies to every school and to every football club throughout the Kingdom. But is the logic of Blantyre sound ? Does an undue proportion of deaths from heart disease cut off erstwhile footballers before they reach their prime ? Again, is the cause of the heart-trouble football, or has Blantyre wit and wisdom excluded the fallacy of acute rheumatism, scarlatina, influenza, and other well-known causes of cardiac disease ? If not, let Blantyre reopen the question and summon to its counsels expert reasoners of medical and forensic fame. Otherwise, to deprive the youth of the district of a manly sport upon theory that will not stand the test of exhaustive criticism will be to bring ridicule upon the ancient name of Blantyre, which Heaven forefend ! Rowing is not a less severe athletic exercise than football, yet it has been proved again and again that men who pull in the great 'Varsity races live a full average life, and are not specially prone to heart disease.

Another Troutbeck Breeze.

Mr. Coroner Troutbeck seems destined to raise eternal storms in his constituency. A few days back he had an altercation with a medical man who refused any information to the Coroner's officer about a patient whom he was called to see twenty minutes before death. The withholding of such voluntary information is part of the concerted action of the medical men of the neighbourhood, who have been excluded by Mr. Troutbeck from making *post-mortem* examinations. In the case in question an inquest was held and the Coroner's favoured pathologist, Dr. Freyberger, gave evidence that deceased died of bronchitis and double pneumonia. The Coroner complained bitterly of the unnecessary burden that had been cast upon ratepayers by the refusal of the medical man to give information, and when the latter attempted to justify his position, proceeded to browbeat him after the fashion of an Old Bailey Justice of former days. It would be well for the ratepayers to understand that it is Mr. Troutbeck who is causing them all this extra outlay, because he thinks their own private medical attendants inferior to Dr. Freyberger. Then, again, he insists upon paying his pet pathologist two guineas for performing a *post-mortem*, for which the general practitioner would receive one guinea. The local medical men have acted wisely in refusing absolutely every jot and tittle of information to the Coroner's officer. They have been grossly insulted and deprived of a legitimate source of income by the man who complains so loudly of their refusal to lend him a helping hand in order to cut down expenses, albeit his wanton extravagance in paying double fees to a pathologist from the North of London has made some effort at retrenchment imperative. Mr. Troutbeck will yet learn the lesson that he is not strong enough to set at defiance a liberal profession like that of medicine, however much he may wish to curry favour with a certain section of faddists in the London County Council, and from whom his inspiration appears to have been originally drawn.

PERSONAL.

The King has been pleased to appoint Staff-Surgeon Arthur Reginald Bankart, M.V.O., R.N., M.B., to be an Honorary Physician to his Majesty.

H.R.H. the Prince of Wales has given £100 in response to the appeal by the Committee of St. George's Hospital on behalf of the Medical School.

Dr. F. H. Aldridge, who has died recently, was an eye-witness of the battle of Inkerman, and of the Balaclava Charge. For some years he was chairman of the Southampton School Board. He took his medical qualifications in the year 1853.

Mr. C. B. Lockwood, the President, will take the chair at the annual dinner of the Harveian Society of London at the Wharncliffe Rooms, Hotel Great Central, London, on Thursday, Nov. 23rd, at 7 for 7.30 p.m.

We are requested to announce that in consequence of unforeseen contingencies Mr. Cockerton, the Local Government Board auditor, has postponed the adjourned hearing of the case before him in which the British Medical Association challenges certain payments made by the London County Council, from Nov. 21st to Nov. 28th, at 11 a.m. This, of course, refers to the notorious Troutbeck-Freyberger controversy.

FOR December 1st it is announced that H.R.H. Princess Henry of Battenberg will open the new Hammersmith Workhouse and Infirmary.

ON December 16th, the handsome new buildings of the Hampstead General Hospital will be formally opened by H.R.H. Princess Christian.

MR. FREDERICK HENRY ALDERSON, M.D.St.And., M.R.C.S.Eng., L.S.A., has been placed on the commission of the peace for the borough of Poole, Dorset.

DR. D. M. McPHAIL, late District Medical Officer, Jamaica, has assumed the duties of Chief Medical Officer at Castries, St. Lucia, West Indies.

A HANDSOME presentation has been made by friends and patients of Dr. J. Hutchinson, after twenty-six years' residence and work in the district of Claybrook Magna, near Rugby, on the occasion of his leaving the parish.

DR. J. LINDSAY STEVEN, physician to the Glasgow Royal Infirmary, has been re-elected Representative to the General Medical Council of the Faculty of Physicians and Surgeons, Glasgow.

DR. W. LOUDON REID, physician for diseases of Women, Western Infirmary, Glasgow, consulting physician to the Glasgow Maternity Hospital, has been elected President of the Faculty of Physicians and Surgeons, Glasgow.

DR. J. D. WILLIAMSON, Physician to the Ulster Hospital for Children and Women, Belfast, has been appointed to the Commission of the Peace for the county.

WE regret to see the names of Dr. and Mrs. Stanley and family among the list of ill-fated passengers on the steamer wrecked a few days since on the rocks of St. Malo.

The petition of Licentiates and Fellows of the Royal College of Edinburgh, praying the College to institute the diploma of Membership, will be presented in Edinburgh on the 24th inst. by a deputation consisting of Dr. Farrer, President, Dr. W. Bell, Hon. Treasurer, and Dr. D. Walsh, Hon. Secretary of the Association of Medical Diplomates of Scotland.

DR. THEODORE FISHER, late Hon. Pathologist to the Bristol Royal Infirmary, has been elected a member of the staff of the East London Hospital for Children.

AT the next meeting of the Therapeutical Society on Tuesday, November 28th, at 4.30. p.m., in the Apothecaries' Hall, Dr. W. C. Dixon will read a paper on the "Physiological Standardisation of Drugs," and Dr. C. O. G. Hawthorne, a note on "Drug Idiosyncrasies in Relation to an Official Dosage."

ON the 7th inst., the Winter Session of the Association of Medical Diplomates of Scotland was opened by a Conversazione at the Medical Society's rooms, Chandos Street, W. A large gathering of members and their friends, including ladies, attended, many of the medical men present being in collegiate robes and gowns. A varied entertainment was provided, including two short concerts and conjuring. The affair was most attractive and successful, and the Association may be congratulated upon its energetic organisation. We learn that a large number of new members have been enrolled.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

GLASGOW.

GLASGOW ROYAL INFIRMARY RECONSTRUCTION.—It is a matter for congratulation that the first step, and an interesting one in connection with the rebuilding of this hospital, was taken a few days ago, when the first brick was laid in position by J. D. Hedderwick, Esq., Chairman of the House Committee, in presence of the managers and members of the staff of the hospital. It is pleasing to know that after long and probably unavoidable delay that a start has now been made. The pressure on the accommodation of the various hospitals—Royal, Western, and Victoria—is considerable, as there are always several hundreds of patients waiting to get into the hospital.

COURT OF SESSION ACTION AGAINST TWO DOCTORS.—DAMAGES CLAIMED £20,000.—In an action raised in the Court of Session, for wrongful incarceration and detention in an asylum, a considerable amount of evidence has been led for the pursuer against a lady and gentleman, members of the profession. As the evidence for the defence has still to be taken, we are not at liberty to comment on the case, further than to say that the case is one which has excited much interest among the members of the profession. There are several points of peculiar interest to the profession at large which it will be our duty to allude to when the decision has been given. Meantime, we venture to draw attention to the serious responsibility assumed by the profession in filling up certificates of insanity.

FACULTY OF PHYSICIANS AND SURGEONS, GLASGOW.—At a meeting of the Fellows of the F.P.S.G., held in the Faculty Hall, St. Vincent Street, last week, the following office-bearers were appointed for the next year:—*President:* Dr. William L. Reid. *Visitor:* Dr. John Glaister. *Councillors:* The President (*ex-officio*), The Visitor (*ex-officio*), The Treasurer (*ex-officio*), Dr. J. Lindsay Steven (as Representative to the General Medical Council), Dr. John Barlow, Dr. Ebenezer Duncan, Mr. J. Walker Downie, Dr. Samuel Sloan, Dr. Robert Perry (Vacancy). *Treasurer:* Dr. W. G. Dun. *Honorary Librarian:* Dr. J. Lindsay Steven. *Board of Examiners for the Licence:* In physics, Dr. James Blyth, Dr. A. Freeland Fergus, Mr. Peter Bennett; in chemistry, Dr. Thomas Gray, Dr. Neil Carmichael, Mr. J. Robertson Watson; in elementary biology, Dr. Thomas Beath Henderson, Dr. Malcolm Lawrie, Mr. James Swanson; in anatomy, Mr. Thomas H. Bryce, Mr. Alex. Macphail, Dr A. M. Buchanan; in physiology, Dr. W. Ernest Thomson, Mr. William Snodgrass, Mr. Robert Fullarton; in pathology, Dr. T. K. Monro, Dr. J. Lindsay Steven, Dr. Charles Workman; in materia medica: Mr. R. Barclay Ness, Dr. Alexander Napier, Dr. J. Wallace Anderson; in surgery and surgical anatomy, Dr. James A. Adams, Dr. John Barlow, Mr. Henry E. Clark, Mr. Henry Rutherfurd, Mr. D. N. Knox; in midwifery, Dr. Robert Jardine, Dr. W. L. Reid, Dr. Samuel Sloan; in medical jurisprudence, Dr. John Glaister, Mr. Robert M. Buchanan, Mr. Hugh Galt; in clinical medicine and surgery, the Physicians and Surgeons of the Royal, Western, and Victoria Infirmaries, being Fellows of Faculty. *Board of Examiners for the Fellowship:* In anatomy, comparative and human, Mr. Alex. Macphail, Dr. A. M. Buchanan, Mr. T. H. Bryce; in physiology, Mr. William Snodgrass, Mr. Robert Fullarton, Dr. W. Ernest Thomson; in pathology, Dr. Charles Workman, Dr. J. Lindsay Steven, Dr. T. K. Monro; in surgery, Dr. James Adams, Dr. D. N. Knox, Mr. Henry Rutherfurd; in ophthalmic surgery, Dr. A. F. Fergus, Dr. A. Maitland Ramsay; in aural surgery, Dr. Thomas Barr, Mr. J. Walker Downie; in medical jurisprudence, Mr. R. M. Buchanan, Dr. E. Duncan, Dr. Carstairs C. Douglas; in dental surgery, Mr. William D. Anderson (*qua* Fellow), Mr. J. R. Brownlie (*qua* dentist); in medicine, Dr. S. Gemmell, Dr. J. W. Anderson, Dr. George S. Middleton; in psychological medicine, Dr.

D. Yellowlees, Dr. Alexander Robertson; in state medicine, Dr. John Glaister, Dr. N. Carmichael, Dr. A. K. Chalmers; in dermatology, Dr. W. G. Dun, Dr. Alexander Napier; in midwifery and diseases of women, Dr. Samuel Sloan, Dr. W. L. Reid, Dr. James Stirton.

BELFAST.

Treatment of the Insane.—A memorandum of an inspection of the Belfast Asylums issued from Dublin Castle this month contains some interesting remarks on the new villas at Purdysburn. There are three of these now in use, accommodating 130 female patients, and two more will shortly be ready. The Inspector says the patients are of the quiet and harmless class, and certainly seem to be happy and contented. There are no bolts or bars to be seen; the windows are large and open freely; the furniture is comfortable and tasteful; there are plenty of books and papers, and the whole air is bright and cheerful. The villas were economical to build, and so far the cost of working has not proved higher per head than in the parent institution. The Inspector concludes by saying that though this plan of treating the insane is still more or less of an experiment it is right that it should be tried, especially as Dr. Graham has given it so much thought and labour. In another portion of his report the Inspector says that much original investigation was carried on in the well-equipped pathological laboratory by Dr. R. A. L. Graham, the second assistant medical officer. "Such work deserved to be mentioned with commendation, especially when met with in one of the Irish asylums, which were much behind the rest of the world as regarded the study of the pathology of cerebral and nervous diseases."

Ballymena Workhouse.—The inspector referred to above also visited the workhouse at Ballymena, and makes some strong observations on the provision, or want of it, for the insane inmates. The living rooms are cheerless in the extreme, badly furnished, and without any books, pictures, or papers, the exercise yards are entirely inadequate, the clothing and bedclothes untidy, the attendance insufficient, the means of escape from fire very deficient, and the general air one of careless squalor, apparently, as shown by such small things as that the potatoes are thrown on a heap on the table, instead of being put into a dish.

Honour to a Medical Man.—On the recommendation of the Marquis of Londonderry, H.M. Lieutenant of co. Down, his Excellency the Lord Lieutenant has appointed Dr. J. D. Williamson, of Belfast, to the commission of the peace for that county. Dr. Williamson is a member of the Belfast Corporation, and is one of the attending physicians of the Ulster Hospital for Children and Women.

Presentation of a Portrait of Jenner.—An interesting ceremony took place at the Medical Institute, Belfast, on Thursday evening, November 16th, when a portrait of Jenner was unveiled at a reception given to the Fellows and Members of the Ulster Medical Society by the President and Mrs. Calwell. The portrait was presented to the Society by Sir Otto Jaffe, J.P., in fulfilment of a promise made by him last year, when as Lord Mayor of Belfast he was a guest at the annual dinner of the Society. The President after expressing the pleasure he had in seeing so many of the members of the Society and their wives present, called on Sir Otto Jaffe. Sir Otto, who was cordially received, recalled the circumstances under which they had last met, when the city was threatened with a serious epidemic of smallpox, and vaccination was heard of on every hand. After referring to the great work of Jenner he said that there were three things he would like them to do to keep his memory green. In the first place they should petition the King to direct that the statue of Jenner in Kensington Gardens be removed to a more prominent place in the new thoroughfare near Buckingham Palace; in the second place they should try to get publishers of almanacs to mark the birthday of Jenner's discovery, the 14th of May, on which he made his first vaccination; and in the third place they should ask Lord Londonderry, their Minister of Education, to induce all school authorities to introduce in the "Common Readers" pieces referring to Jenner and vaccination.

In the absence of Lady Jaffe the portrait was unveiled by her sister, Mrs. Joel. Sir William Whitla moved a vote of thanks for the gift, which was seconded by Dr. John Campbell, and passed by acclamation. During the evening a programme of music was rendered by Wright's Orchestra, Miss Kathleen Warwick sang, and Miss Eva McKisack gave two recitations. Most of the Fellows and Members of the Society and a large number of ladies were present.

Correspondence.

THE HUNTING OF THE DEER.

To the Editor of The Medical Press and Circular.

Sir,—Many readers of the Medical Press not members of the profession will be glad to see the article under the above heading in your issue of November 15th. There are two aspects in which wantonly cruel sport may be viewed, one which regards the suffering of the hunted creatures, the other which considers the demoralisation of the hunters. I live on the verge of a Surrey common, in the Reigate district, in the country of one pack of stag hounds, and near the country of others. On several occasions in recent years scenes of horrible cruelty, often witnessed by crowds of village children, and similar to those referred to in your article have occurred close to my residence; and many others have been reported at other places near. There is also in the neighbourhood a private pack of beagles. These are followed on foot by local gentry accompanied by crowds of boys and girls, mostly of the wealthier classes. Hardly anything could be more cruel than this form of sport. The dogs hunt by scent and are slow runners. The aim is to have a long run, which means the chasing of the hare till it falls exhausted and screaming into the jaws of the hounds. Is it possible that any but an evil effect can be produced upon gentle children by this lesson in pure selfishness—the pursuit of pleasure, regardless of the terror and pain inflicted upon the helpless victims. It is much more cruel than fox-hunting or bull-fighting; for in these cases the animals die game. The cruelty of battue shooting is constantly exemplified all over the country; and it is only within the last day or two that one of my dogs brought out of a wayside hedgerow a wounded and helpless pheasant, which had evidently lain there for many hours. And yet noble sportsmen like Lord Portland and Lord Llangattock, who cultivate on a grand scale sport involving such cruelty, are among the chief supporters of the antivivisection propaganda. To account for their attitude forms an interesting psychological problem, and it is even more difficult to account for the attitude of prominent prelates of the Church of England among whom Canon Wilberforce has been perhaps the most conspicuous. Whether intended or not the preachings and teachings of these men have been widely interpreted as implying scorn of science and the scientific method. I have not the least doubt that these teachings have helped to a large extent in filling the ranks of Christian Science and other cults of the kind, such as esoteric Buddhism, now fashionable. The qualification of the neophyte in these new religions is expressly stated to be either complete ignorance or renunciation of science. An open mind is called for ready to believe any impossible statement, or even to believe it because it is impossible. The followers of these cults are largely educated and cultivated people. It is a queer and sinister sign of the times.

I am, sir, yours truly,

A Psychological Amateur.

November 16th, 1905.

Laboratory Notes.

ROBB'S NURSERY FOODS.

CONSIDERING the enormous number of infants who are fed artificially, it is astonishing that the practitioner, as a rule, pays so little attention to the merits or demerits of the various foods he prescribes. This is the more startling when one remembers the large number of infantile complaints due entirely to the use of unsuitable foods, and the consequent depreciation in his reputation as an authority on baby-feeding. Perhaps the chief reason for this ignoring of the chemical composition of the baby's diet is accounted for by the misleading analyses so frequently met with. We have recently seen a food stated to contain no unaltered starch which showed microscopically that it consisted chiefly of entirely unaltered starch granules. The safest way is only to consider those analyses and reports by reputable medical journals which have actually *analysed* the food and not written a "puff" on the food from pamphlets supplied by the manufacturers. Bearing in mind that *all* sterilised foods may be responsible for scurvy, there are certain foods which bear a searching chemical analysis well, and one of these is the food under consideration. We have made a careful analysis of Robb's Soluble Milk-Food (No. 1) (Alex. Robb and Co., London), and our analysis practically confirms that given in the accompanying pamphlet. A very satisfactory feature is that we find it to be free from starch and cane sugar. The amounts of fat and proteid are in suitable proportions, and the taste and odour closely resemble those of mothers' milk. We have therefore every confidence in bringing his food to the knowledge of our readers as a most suitable food for infants up to the age of four months, after which the Number 2 food is recommended until seven months. A useful table is given showing the quantity of food to be taken at each meal, and the length of time between each for varying ages.

Our analysis is as follows :—

Carbohydrates	63.14 per cent
Moisture	2.96 „ „
Fat	18.92 „ „
Proteids (containing 1.89 per cent. nitrogen)	11.96 „ „
Mineral Matter	3.02 „ „
Starch	absent
Cane sugar	absent
	100.00

Obituary.

ANDREW BROWNE, L.R.C.S.ED., L.F.P.S.GLAS., OF BRADFORD.

MR. ANDREW BROWNE, a Bradford medical man, who had done much valuable service in connection with the St. John Ambulance Association, died on the 15th inst., at his residence. About four years ago Mr. Browne had an apoplectic attack which incapacitated him from following his profession, and for the past two years he had been confined to the house. He took the L.R.C.S.Ed. in 1873.

JAMES GRAY, M.D.ST.AND., OF GLASGOW.

DR. JAMES GRAY, one of Glasgow's oldest medical practitioners, died on the 16th inst. at the advanced age of eighty-six. Dr. Gray was a native of the Fair City, his father being manager of the Perth Waterworks. He studied in Edinburgh University, and thereafter took his M.D. degree at St. Andrews. About sixty years ago he began practice in Glasgow, and was much appreciated and loved by his patients. He was a man of strong personality, whose heart was in his profession. Dr. Gray was the medical attendant to the Magdalene Institution, Maryhill, which position he held till his death.

FREDERICK HENRY ALDRIDGE, M.D.ST.AND., J.P., M.R.C.S.ENG.

THE death is announced from Southampton of Dr. Aldridge, a well-known passive resister. Dr. Aldridge was a justice of the peace, a prominent public man, and served on the Army Medical Staff during the Crimean War. He was seventy-five years of age. He graduated M.D.St. Andrews, and M.R.C.S.Eng. in 1853.

Literature.

SQUINT. (*a*)

THE first edition of Worth's Squint has already brought its author into repute as an original ophthalmologist whose views are likely to become accepted doctrines when they have been sufficiently tested by fellow-workers. The treatment of squint has long been the bugbear of the ophthalmic surgeon who was concerned to cure the patient and not merely to improve his appearance. The routine treatment by glasses, and, if glasses failed, by tenotomy, could not hold the field as a final settlement of the difficulty, and years ago Mr. Worth set himself to work to carry the matter further. Squint he shows to be due—speaking of the convergent strabismus of childhood—to the abnormal convergence of the visual axes plus a defect of the fusion faculty. This latter is the important point. The fusion faculty may not have developed from congenital inability, or one eye may be so defective that in practice it is not used, and the fusion faculty is never acquired in consequence. Even when the squinting eye has good visual acuity, the patient may learn to disregard the image it receives, and to depend wholly on that seen by the fixing eye. The treatment of squint is to catch the patient young, correct any refractive error present, and then train him to use both his eyes together, and to fuse the images he receives. Much time and patience are often necessary satisfactorily to accomplish this, but by aid of the amblyoscope and personal encouragement success may be obtained. Mr. Worth lucidly describes his advancement operation which has already gained favour in this country and abroad, and he narrates all the small details which are necessary to success. We have not space here to enter into a discussion on all the points raised in this book, interesting and important as they are—but it is a pleasure to be able heartily to recommend it to all practitioners of ophthalmology as a record of sound, painstaking labour brought to a successful and gratifying conclusion.

DIETETICS IN THE CAUSATION OF DISEASE. (*b*)

DR. SIM WALLACE has done well to bring together in one volume many most suggestive and eminently practical essays which have appeared in various medical periodicals. The author, as a dentist capable of viewing his specialty from the broad standpoint of the scientific physician, throws much light on dental disorders and general derangements arising from errors in mastication, bad selection of food, and improper and imperfect preparation of nutrients. Each essay merits careful perusal, and special attention should de paid to those on "nasal obstruction and mouth breathing" and "physical deterioration in relation to the teeth." The book should be read by every physician, dentist and intelligent parent.

A VOLUME of "Counsels and Ideals from the Writings of William Osler," Regius Professor of Medicine at Oxford, is announced by Mr. Henry Frowde. It has been compiled by Dr. C. W. B. Camac, of New York who explains that "for his own purposes, in order to renew from time to time the personal influence which as pupils and *internes*, we had come to depend upon" he had for some years made extracts from Dr. Osler's lectures and addresses. The same publisher has nearly ready for publication a Memoir of Miss Catharine Grace Loch, Royal Red Cross, Senior Lady Superin-

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(*a*) "Squint : its Causes, Pathology, and Treatment." By Claud Worth, F.R.C.S. Second edition. London : John Bale, Sons and Danielsson, Ltd. 6s. net.

(*b*) "The Role of Dietetics in the Causation of Disease." By Dr. Sim Wallace, M.D., D.Sc., L.D.S. Pp. 87. London : Bailliere, Tindall and Cox.

tendent Queen Alexandra's Military Nursing Service for India, written by Surgeon-General A. F. Bradshaw, who was Principal Medical Officer to the Forces in India.

Medical News.

Medals for Civil Surgeons—South African War.

An official notification has been sent to us from the War Office, stating that medals or clasps for the undermentioned gentlemen who served as civil surgeons in South Africa, and whose addresses are unknown, await issue at the War Office. Application for these should be made to the Secretary, War Office, 68, Victoria Street, London, S.W.

Albertyn, J.
Aldred, A.
Alexander, K. B.
Allport, P.
Bayley, P.
Bishop, W. O.
Booth, R. R.
Calder, W. J.
Clark, M.
Clarke, G.
Clarke, W.
Crean, G. G.
Dunlop, C. D.
Elmes, H.
Fehso, J. McCall
Fenton, J.
Froud, W.
Fryer, R. C.
Galbraith, H. T.
Gillanders, I. L. G.
Gilbert, R. G.
Gillespie, J.
Goule, H.
Hangen, T. M.
Hart-Jackson, W.
Harvey, H.
Harwarden, G. F.
Hibberden, G. A.
Horne, H. R.
Hudson, W.
Hunter, C. W.
Hunter, F. A.
Johnson, T.
Jones, G. B.
Klein, M.
Kerr-Bell, T. J. H.
Langdon, D. C.
Leslie, G. W.
Loeser, H. A.
Lundie, G. F.
Mentell, H. T.
Mate, W. F.
McDougall, A. H.
Milne, J. E
Nangle, J.
Nixon, E. A.
O'Connor, C. E.
Ogle, A.
O'Farrell, F. J.
Parkinson, W. G.
Peters, C. A.
Phillips, N. C.
Ralston, F. C.
Riordan, H.
Robertson, W. R.
Rowland, F.
Short, W. R.
Simon, E.
Simon, W.
Smith, W. H.
Somerville, W.
Stephen, L. N. G.
Stow, F. E.
Thomas, F. C. M.
Thomas, H. S.
Tucker, J. A.
Twigg, E.
Visser, J.
Warren, T.
Wellford, F.
Wilkinson, R. H.
Woodhouse, W. B.

Hydropathic Establishment in the Holy Land.

A correspondent writes us that to those visiting the Holy Land needing also curative treatment, it will be an interesting announcement that a hydropathic establishment has just been founded in the healthiest part of modern Jaffa (Palestine), on a splendid promenade overlooking the sea, and commanding a fine view of the old historic town. This institution was erected in response to one of the most crying needs of the country. Hitherto the people of Jaffa and Jerusalem suffering from gout, rheumatism, sciatica, and various neurotic complaints were obliged either to endure helplessly at home, to undertake the tedious and wearisome journey by mule or donkey to the hot springs of Tiberias, or, if circumstances permitted, to have recourse to the treatment at Carlsbad. These difficulties and inconveniences have now been overcome and the "Bella Vista Hydropathic Establishment" is now open, managed by an efficient staff of trained workers. Communications must be addressed to the Lady Superintendent, Mrs. Margaret A. Palmer.

Irish Medical Schools' and Graduates' Association.

The autumn dinner of the Irish Medical Schools' and Graduates' Association will take place at the Hotel Cecil, on Tuesday, the 28th inst., at 7 o'clock, p.m., when Sir W. Whitla will preside. The dinner will be followed by an entertainment and Smoking Concert, All tickets to be obtained from Mr. E. Canny Ryall, 145, Harley Street, London, W.

Disastrous Fire at a Medical Publishers.

Messrs John Wright and Co., the well-known Bristol medical publishers and printers, were the victims of a disastrous fire arising in a neighbouring warehouse a few days ago, the whole of their offices, factory, and stock being entirely destroyed. They ask us to state, however, that there are a few copies of most of their publications at their London agents, Messrs. Simpkin and Co., Ltd. These can be supplied so long as any remain. In the meantime, a re-start has been made in a temporary factory, and most of the volumes are now reprinting by themselves and by other firms throughout the country. In a few weeks they hope to re-issue the most urgent volumes and confidently trust to the forbearance of their friends for any temporary inconvenience thus unavoidably caused.

A Medical Man released from Penal Servitude.

We learn that Dr. Timothy Jones, who was sentenced to penal servitude for life at Swansea, more than ten years ago, on a charge of manslaughter, by performing an illegal operation upon a young woman, was released from Parkhurst Prison on Thursday by order of the Home Secretary, as the result of a petition which had been presented appealing for his liberation.

Pass Lists.

Trinity College, Dublin, Michaelmas, 1905.

Final Medical Examination—Section A.—George F. Graham, Henry J. Keane, Richard G. S. Gregg, Charles H. O'Rorke, Frederick Stevenson, Ernest T. Jameson, Henry de C. Dillon and James D. K. Roche (equal), Bethel A. H. Solomons, Francis W. H. Bigley.
Royal College of Surgeons, Ireland.

Dental Examination.— The following candidates having passed the necessary examination have been admitted Licentiates in Dental Surgery:—E. Bermingham, J. W. Harvey, W. G. G. Quinn, and J. Walker.

The following candidates have completed the primary part of the examination:—N. Allaun, J. E. Hogan, C. J. Hyland, P. D. McCreery, and F. C. Warren.

Society of Apothecaries of London.

The following candidates, having passed the necessary examinations, have received the L.S.A. Diploma of the Society, entitling them to practise Medicine, Surgery, and Midwifery: A. Bernfeld, R. Heathcote, M. O'Brien, G. H. Rains, and C. A. Sampson.

The following candidates have passed in:—

Surgery: A. Bernfeld (Section II.), R. Heathcote (Sections I. and II.), M. O'Brien (Sections I. and II.), G. H. Rains (Sections I. and II.), C. A. Sampson (Sections I. and II.).

Medicine.—H. S. Burnell Jones (Section I.), W. G. H. Cable (Section II.), C. F. Kernot (Section I.), M. O'Brien, (Sections I. and II.).

Forensic Medicine.—H. S. Burnell-Jones, R. C. T. Evans, M. O'Brien.

Midwifery.—L. C. W. Brigstocke, M. O'Brien, A. P. Wright.

A meeting of the Council of the Invalid Children's Aid Association will be held on Thursday, November 30th, at 4 p.m., at Denison House, Vauxhall Bridge Road, when Sir William Broadbent will give an address on "The Tuberculous Children of the Metropolis," and a general report will be given of the work of the Association.

Regulations have been made for the Begby Scholarship in connection with the Royal College of Surgeons, founded by Mrs. Begby, in memory of her husband, a former member of the College. The scholarship, of the value of £20 per annum, will be open to any candidate admitted to the second examination of the Joint Examining Board of England held in 1906. It will be awarded to the student obtaining the highest marks in anatomy.

Notices to Correspondents, &c.

☛ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, to avoid the practice of signing themselves "Reader," "Subscriber, "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

ETONIENSIS.—The emotional condition is probably associated with the curious and interesting group of symptoms known as neurasthenia. The high frequency current is sometimes successful in these cases, which are admittedly difficult to treat. Moral influences are as a rule essential to cure. Drugs are indirectly valuable.

A. D. L. (Yarmouth).—Very good radiograms are obtainable in most cases of abscess in bone, and any rate in the hands of good operators. The diagnosis of such cases by ordinary methods is often exceedingly obscure, but if there be any suspicion of deep-seated abscess it would be safer to have an x-ray photograph taken.

"A CONCEPTION OF DISEASE."

Suggested by Sir F. Treves' paper in last *B. M. J.*

So Malta Fever starts from milk!
How did the goat get fever?
And if the goat could tell you how
Of course you won't believe her.

How are her kids from fever free?
Whose diet cannot alter,
Substitute Horlick's Malted Milk!
Instead of milk in Malta!

When fleas on rats could not be found,
The plague then showed abatement,
That "rats are liable to plague,"
Seems an erratic statement.—A.D.

MOTORIST.—A correspondent writes us suggesting a special article on motors, the "Medical Profession and Motors." The subject has been before us for some time, and we hope to be able to lay before our readers some useful information upon this topic. We often hear that "the motor has come to stay," and we quite believe that the medical profession as a class, will find this means of rapid transit a great boon. We beg to thank "Motorist" for his suggestion.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 22nd.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus).—8.30 p.m. Clinical Evening.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mrs. C. Ryal: Clinique. (Surgical). 5.15 p.m. Dr. L. Guthrie: The Treatment of Hemiplegia and Ataxia.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. R. H. Cole: Insanity and Law.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (North-Eastern Fever Hospital, St. Ann's Road, N.).—2.30 p.m. Dr. F. M. Turner: Demonstration on Fevers.

THURSDAY, NOVEMBER 23rd.

HARVEIAN SOCIETY OF LONDON (Hotel Great Central). Annual Harveian Dinner.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. A. W. Mayo Robson: Cholecystectomy.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Edwards: Renal Stone.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Coccous Diseases: I., Impetigo Contagiosa; II., Furuncle; III., Carbuncle; IV., Coccogenic; Sycosis (Chesterfield Lecture.)

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. T. D. Lister: Demonstration of Selected Cases. (Post-Graduate Course.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture-Demonstration:—Mr. A. de Prenderville: Anæsthetics.

FRIDAY, NOVEMBER 24th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.). 8.30 p.m. Papers:—Dr. S. West: (1) Case in which the Pleura contained Several Pints of Calcareous Mortar-like Fluid; (2) Periodic Respiration.—Dr. Langmead (introduced by Dr. Garrod): A Case of Relapsing Tetany associated with Dilatation of the Sigmoid Flexure.—Mr. W. G. Spencer: Septic Peritonitis occurring Early in the Course of Typhoid Fever apart from Perforation.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. E. Waggett: Clinique. (Ear.)

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. Abraham: Cases of Skin Disease.

Vacancies.

Assistant Medical Officer wanted.—Salary £120 per annum, with board, furnished quarters, and washing. Applications to Dr. Richardson, Lunatic Asylum, Isle of Man.

Barra Parish Council.—Medical Officer. Salary £119 per annum. Applications to Thomas Wilson, Solicitor, Lochmaddy, Clerk.

Newport Borough Asylum, Caerleon, Mon.—Assistant Medical Officer. Salary £150 per annum, with board, apartments, and attendance. Applications to the Medical Superintendent, Newport Borough Asylum, Caerleon, Mon.

State Criminal Lunatic Asylum, Broadmoor, Crowthorne, Berks.—Junior Assistant Medical Officer. Salary £200 per annum, with furnished quarters, coal, gas, and attendance. Applications to the Medical Superintendent.

University of Durham College of Medicine, Newcastle-upon-Tyne.—Demonstrator of Physiology.—Salary £200 per annum. Applications to Professor Howden, Secretary of the University of Durham College of Medicine, Newcastle-upon-Tyne.

West Riding Asylum, Wakefield.—Pathologist and Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Director.

Western Skin Hospital.—Honorary Physician Electrical Department. Applications to the Secretary. (See Advt.)

Western Skin Hospital.—Honorary Pathologist. Applications to the Secretary. (See Advt.)

Whitehaven and West Cumberland Infirmary.—Resident House Surgeon.—Salary £120 per annum, with board and lodging. Applications to W. H. Sands, Secretary.

Appointments.

ALLAN, HERBERT WILLIAM, B.A.Cantab., L.R.C.P.Lond., M.R.C.S. Medical Officer of Health of Wells (Somerset) and Superintendent of the Isolation Hospital.

ANDREW, JAMES GRANT, M.B., C.M., F.F.P.S.Glasg., Surgeon to the Victoria Infirmary, Glasgow.

BARRETT, H. E., M.R.C.S., L.R.C.P.Lond., Third Anæsthetist to the London Throat Hospital.

BASCOMBE, E. D., L.D.S.Eng., Dental Surgeon to the Royal Victoria Hospital, Bournemouth.

BIRCHALL, H. A. L., L.R.C.S.Irel., L.A.H.Irel., District Medical Officer by the Redruth (Cornwall) Board of Guardians.

CARRINGTON, GEORGE HEDWIG, M.R.C.S., L.S.A., D.P.H.Lond., a District Medical Officer by the Poole (Dorset) Board of Guardians.

CORMAC, H. DOVE, M.B., M.S.Madras, Second Assistant Medical Officer, Cheshire County Asylum, Parkside, near Macclesfield.

EDWARDS, R. T., M.R.C.S.Eng., L.R.C.P.Lond., Examiner to the St. John Ambulance Association.

GALSWORTHY, LAURENCE, M.R.C.S., Honorary Anæsthetist to the Italian Hospital, Queen Square, London W.C.

HENDERSON, ROBERT G., M.A., M.B., Ch.B.Aberd., F.R.C.S.Edin. Honorary Pathologist to the Oldham Infirmary.

JONES, PIERCE, M.B., B.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Portmadoc District of the counties of Carnavon and Merioneth.

KYFFIN, J., L.R.C.P.Lond., M.R.C.S., Certifying Surgeon under the Factory and Workshop Act for the Gosport District of the county of Hants.

OWEN, SYDNEY A., B.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P., Resident Medical Officer at the East London Hospital for Children, Shadwell.

PRITCHARD, JOHN LLEWELLYN, L.R.C.P.Lond., M.R.C.S., Assistant Medical Officer at the Joint Counties Asylum, Carmarthen.

ROBSON, W. M., M.D.Lond., M.R.C.P.Lond., Honorary Assistant Physician to the General Hospital, Northampton.

Births.

THOMAS.—On Nov. 16th, to Dr. and Mrs. Wynne Thomas, Thornbury, Bromley, Kent, a son.

TWEEDY.—On Nov. 14th, at the Rotunda Hospital, the wife of E. Hastings Tweedy, F.R.C.P.I., of a son.

Marriages.

SNELL—WRIGHT.—On Nov. 17th, at Clapham, Edward Arthur Snell, M.B.Lond., M.R.C.S., of 70 City Road, London, and Buckhurst Hill, to Florence Louise, only daughter of Mr. and Mrs. Philip Wright, of Clapham.

Deaths.

DE RENZI.—On Nov. 8th, Henry C. C. Renzi, M.R.C.S., L.S.A., youngest son of the late Rev. G. B. De Renzi, formerly Chaplain of H.M. Prison, Wandsworth, and Louisa De Renzi, of 10, Brodrick Road, Upper Tooting, London, aged 36 years.

RATTRAY.—On Nov. 15th, at Rannaguizion, Cheltenham, Adelaide, youngest and only surviving daughter of the late Charles Rattray, M.D., of Daventry, Northamptonshire.

SHORTO.—On Nov. 18th, at 121 Hartfield Road, Wimbledon, Frances Jane Blake, widow of the late James Reeve Shorto, M.R.C.S., L.S.A., formerly of Southampton, in her 67th year

TAYLOR.—On Nov. 15th, at 3 Lorraine Road, Holloway, London, Charles Taylor, M.R.C.S., aged 75 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, NOVEMBER 29, 1905. NO. 22.

Original Communications.

ON SOME THERAPEUTICAL APPLICATIONS OF CONTINUOUS CURRENT. (*a*)

By ARTHUR HARRIES, M.D.,

Fellow of the Society; formerly Physician to, and Lecturer on Clinical Dermatology at, St. John's Hospital for Diseases of the Skin (1884-1888).

IN previous papers at the Institution of Electrical Engineers (*b*) and Section G at the British Association in 1890, (*c*) I have dealt with the resistances offered by the living human skin relatively to continuous and to alternating currents, both battery-produced and dynamo-produced, and for various reasons, which would take too long to set forth here, decided many years ago to concentrate my investigations chiefly on the therapeutical effects of the applications of current obtained by the use of *batteries* connected up either *in parallel* or *in series*.

Accordingly, all the examples that I am about to give you have been obtained with the aid of continuous current (battery-produced), under the following conditions:—

(*a*) The areas and sites of contact of the electrodes have been reasonably suited to the immediate purposes in view. That is to say, that in some cases large or small, flat or rounded, electrodes (covered with flannel or chamois leather), and in others bare metal electrodes of suitable shape and arrangement, have been employed.

The question of area of contact is especially important, inasmuch as the *quantity* of continuous current passing through a given resistance bears a close relationship to this factor.

(*b*) The period of soakage, and the fluid employed for such soakage, next demand attention. Resistance has been found to vary inversely at the time of contact with any particular medium. Thus, the late Mr. Lant Carpenter discovered, in some of his experiments, that the resistance of the body from foot to foot varied from 10,300 ohms (with dry skin) at the moment of contact, to 4,300 ohms at the end of one minute's soakage with salt and water; and to 1,400 ohms at the end of 30 minutes of such soakage. These broad results have been confirmed by many experiments referred to in the joint papers already quoted, and by subsequent observations in my own practice.

(*c*) That there shall invariably be a calibrated milliamperemeter in circuit, because—

(1) The E.M.F. of batteries constantly diminishes with time, and with the employment of the cells.

(2) Resistance of the skin varies largely in different individuals, as well as in the same individual, at different times and at different parts of the body.

(3) Further, the total body-resistance to be overcome varies, naturally, with the distance between the electrodes, with their absolute area, and with their area relatively to each other.

(*d*) It is scarcely necessary to add that the whole apparatus should be tested as to its efficiency previously to each application.

The effects of soakage depend largely upon the solution employed. Thus, distilled water has a relatively high internal resistance as compared with tap water, while a 50 per cent. salt solution has a much lower internal resistance as compared with the latter, though itself showing a higher internal resistance than a 5 per cent. solution of iodide of potassium.

These percentage strengths are, of course, only named for the purposes of comparison.

EARLY EXPERIMENTAL FAILURES.

I must ask your indulgence for having reminded you of these essentials. Both in the United States and in this country, tentative experiments, under defective conditions, have naturally resulted unfavourably. In some of the text-books the authors have even been rash enough, on what I venture to consider insufficient grounds, to consign the continuous current and all its applications to comparative oblivion. My object, therefore, is to endeavour to show you, by a series of selected cases, that, when accurately employed, continuous current has valuable therapeutical powers. Many of you present may recall that, some twenty years or so ago, similar hasty and erroneous deductions were drawn from the partial failure of the attempts made to employ electricity for lighting purposes. It is not necessary to follow the parallel further.

FUNCTIONS OF CONTINUOUS CURRENT.

The functions of continuous current which immediately concern us may be divided as follows:—(1) Mechanico-physical (cataphoresis); (2) electro-chemical (electrolysis); (3) electro-physiological (catalysis). Each of these is, of course, capable of subdivision, and many of these sub-divisions will occur to you. It may be added that my work is based largely upon the theory of the dissociation of electrolytes into anions and kations when a continuous current is passed. I have selected the following typical cases to illustrate these functions. In every instance, the diagnosis has been made by independent medical men, and nearly always in these cases treatment has been carried out in presence of members of the profession other than myself.

CATAPHORESIS.

CASE. I.—*To illustrate Cataphoric Anæsthesia.*—Mr. H., æt. 58, a case of rachialgia, diagnosed by the late Dr. Charcot, and ordered by him to undergo repeated applications of galvano-cautere to the region of the lower cervical and upper dorsal spine. The patient had a dilated right heart and other cardiac insufficiency, and it was not deemed prudent to give

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(*a*) A paper read before the Therapeutical Society. Apothecaries' Hall, London, October 25th, 1904.

(*b*) *Journal* of the Institution of Electrical Engineers, vol. XIX., No. 86.

(*c*) *Transactions* of the British Association, Leeds, 1890.

him a general anæsthetic. His son-in-law, a medical man, came with him to me, and it was decided to carry out Dr. Charcot's suggestion. The skin, having been first soaked with 5 per cent. salt and water solution for twenty minutes, was subjected over the area to 30 cm. by 10 cm. during half an hour, along one side of the lower cervical and upper dorsal spine, to the action of a continuous current. Thirty to forty ma. were passed through a flannel-covered anodal electrode, saturated with a 10 per cent. solution of hydrochlorate of cocaine. The kathodal electrode—twice the area of the anodal—soaked in 5 per cent. salt and water solution, was placed upon the lower front of throax and upper epigastrium. Six galvano-cautere linear scarifications, each five centimetres long by half a centimetre deep, were made opposite as many intervertebral spaces. In *The Lancet* of October 25th, 1890, page 869, in describing this case, I stated: "The patient did not flinch, but expressed his perfect willingness to undergo a similar operation again if necessary." This, in fact, he did on two subsequent occasions, the results as regards painlessness being similar. The persistent objection to cataphoric medication is, that we have no ready means of estimating the actual quantity of drugs passed through the skin.

"But, as a matter of probability, and of experience in a good many cases, the quantity passed is really very small, though it is sufficient so to anæsthetise the skin as to render it capable of bearing, without difficulty, contact with a white-hot platinum wire, heated by the electric current. Further than this, no immediate after-pain or sense of burning was experienced in the parts submitted to operation, though it is not certain that this is due to cocaine alone. I have noticed similar freedom from pain *after* applications of the galvano-cautere under chloroform. In every instance in which I have employed cocaine by cataphoresis, careful inquiry has been made as to the existence of after-toxic symptoms, always with a negative result."

Three sets of operations were undertaken, each being carried through in the manner described above. These were: (1) Six scarifications on the right side; (2) after an interval of five days, six corresponding scarifications on the left side; and (3) after a further interval of ten days, six intermediate scarifications joined the lateral sets. There was no shock at any stage of the procedure; no unpleasant sequelæ; and the ultimate results were satisfactory.

Case II.—*To illustrate Cataphoric Medication.*—Miss B., æt. 39, had suffered for six years or longer from arthritic fixation of practically all the joints of both upper and lower extremities. These had been repeatedly broken down at a county hospital, but had as frequently relapsed into the old condition. The patient could neither walk, feed herself, nor help herself in any way involving movement of the limbs.

So many joints needing attention, a series of operations was necessary, and each of these was carried out in presence of several medical men. On the first day I broke down, under chloroform, twenty-seven joints of the upper extremities in such a way as to admit of free movement. Subsequently, a ½ per cent. solution of iodine in aqueous iodide of potassium was passed directly into the joints by the aid of a suitably arranged anodal electrode, a current of 30 ma. being used. The application was employed and repeated for periods of half-an-hour twice a day, during a series of days. The kathodal electrode was of approximately twice the area of the anodal, and was in contact with a proximal portion of the same limb. Each cataphoric application was preceded by soakage, as in Case I., and succeeded by passive movements of the particular joints under treatment. Similar procedure was adopted in the repeated subsequent operations, viz.: (*a*) breaking down under chloroform; (*b*) soakage; (*c*) cataphoric medication with the iodine solution described; (*d*) passive movement.

At the end of three weeks, the majority of the affected joints had been brought into use, and the patient was able to feed herself and to knit quite comfortably. The larger joints of the lower extremity were about to be dealt with, when the patient objected to further treatment because, as she informed the nurse, it would mean that she would be well enough to work for her living. This was apparently the last thing she desired, as she had for years been an object of charity.

Before turning to another function of the continuous current, I may be permitted to quote further from the paper to which I have above referred. I have used cataphoric medication in the practical and frequently successful treatment of many skin lesions, as well as arthritic, syphilitic, glandular, and other affections.

"The plan is not new (1890), for it was introduced as a physiological experiment some years ago in Germany; but so far as I am aware, such previous attempts as have been made in this country to bring cataphoresis into practical use have been only partially successful, because (1) the requisite conditions have been neglected; (2) the currents used have been too feeble, and applied for too short a time; (3) the operators seem to have been lacking in patience, and often in knowledge of the instruments employed; (4) the reversals recommended in the text-books are not only useless, but worse than useless, for they tend to counteract any movement of the fluid in a particular direction which may already have been set up by the current.

"Cataphoric medication is indicated in many cases hitherto laboriously treated by ointments, lotions, and subcutaneous injections, and it is not to be doubted that by its agency we are able to bring our remedies into direct apposition with the actual sites of disease, and thus to increase the possibilities of successful treatment of many lesions, not only in the direction of rapidity, but in that of pleasantness and of safety."

The experience of many cases of cataphoric medication during the years that have intervened since the date of this paper (1890) has served to confirm and to emphasise the conclusions which I then brought to the notice of the profession. In The Medical Press and Circular of December, 1889, I had previously described the method adopted in such cases.

C.C. from the main would conceivably be of much service in cataphoric applications, but of this I have no experience.

Case III.—*To illustrate Electrolysis.*—Mr. L., æt. about 38, had been suffering from stricture of the urethra for many years, and when I saw him at the Doncaster Infirmary, in consultation with Dr. Christy Wilson and several of his colleagues, there had been retention of urine for some thirty hours. The patient and his friends had declined to allow any cutting operation to be done, and it was decided to attempt to pass a bougie-electrode into the bladder. An anodal pad, 15 cm. by 10 cm., soaked in 5 per cent. salt and water solution, was placed over the lower part of the abdomen, and a rheophore connected with the negative pole of the battery was in readiness to be connected up with the bougie-electrode when in position. A No. 3 (English gauge) was first used, and passed without resistance for about four inches, when further passage was interfered with by the stricture. It was then connected up with the rheophore, and a current, beginning with 5 ma., and increasing slowly to 10 ma., was passed through. Gentle pressure soon carried the electrode through the resistance, and with two or more short stoppages, due to additional contractions, the bougie was passed into the bladder, when the current was immediately switched off. The electrode was now withdrawn, and metal terminals of increasing size were similarly passed without any difficulty into the bladder by aid of a 10 ma. current until a No. 8 (English) had gone through. The full time occupied was ten minutes, and Dr. Wilson easily passed a No. 8 catheter.

Case IV.—*To illustrate Electrolysis and Catalysis.*—Mr. B.H.F., æt. 44, born in South Africa of British parents, was in the habit, from time to time, of making long expeditions for large game hunting into the interior of Central South Africa. The last expedition prior to my seeing him had entailed some six months of practical living in the saddle. The latter part of his journey was marked by prostatic pains, which persisted after the end of the expedition. These pains were succeeded by the usual signs of prostatic obstruction, including the necessity for frequent micturition at night. Treatment in South Africa failed to relieve the patient. He consequently came to England and consulted consecutively two eminent surgeons, since deceased. Each of these gentlemen diagnosed prostatic enlargement, and each advised a suprapubic operation for its relief. On examination per rectum, I found general enlargement, with slight tenderness over the middle lobe, and the prostatic urethra only allowed a bougie equal to No. 6 (English) to pass. No urine came away from the bladder until the eye of a catheter had been passed over eight inches.

It was arranged to give the patient a series of sittings with the bougie-electrode. Commencing with a No. 6 passed into the prostate, connected with the negative pole of the battery, and using a current of 7 to 8 ma., for a period of twelve minutes on alternate days, I found that, after ten sittings, a full-sized bougie-electrode could be comfortably passed. The necessity for nocturnal micturitions had disappeared, as well as all tenderness of the prostate, and the latter was now almost normal in size. Three subsequent sittings were given of similar type, and the patient went home practically well.

The early development of prostatic enlargement in this case, as the results of pressure and irritation set up by continuous riding, may possibly account for the rapid manner in which electrolytic treatment caused disappearance of the conditions.

It is, however, only right to add that several subsequent cases of enlarged prostate, developing at normal age (55-65) and similarly treated, have also done well.

Electrolysis in the Treatment of Neoplasmata.

Twenty years ago, at St. John's Hospital for Diseases of the Skin, I undertook many operations of the usual type for the treatment of lupus. At more than one of these operations, a well-known bacteriologist attempted to obtain cultures of the lupus bacillus by passing lupus nodules direct from the living subject into the culture solutions. His efforts, however, met with no success, and subsequently a colleague and I attempted the same thing under conditions of temperature and culture fluids approximating as nearly as possible to those found in the living body, equally without success. We also made microscopical sections of frozen lupus nodules, and found the bacilli, indeed, but few in number and *deeply placed.*

Former methods, such as plugging with germicides the spaces left after scraping or punching out the nodules, met with a fair measure of success in cases of early development. Where recurrence took place was when the scraping or punching had not been carried deeply or widely enough, and when, consequently, the germicide had not come into direct contact with the whole of the basal portions of the nodules.

These repeated experiments suggested to me a possibility that the passage of an electrolytic needle along the base of each nodule might be of some use. Accordingly, in many cases where early developments in the shape of apple-jelly nodules were present, whether alone or accompanying patches of deeper destruction of tissue, I passed a platinum needle under the base of each nodule, adopting this method, first of all, in the case of a nurse from the North-Western Fever Hospital sent to me by Dr. Gayton. The needle was made the cathode of a c.c. battery and the anode was a pad of varying area (from 50 to 150 sq. centimetres) placed conveniently near. A current of from 5 to 10 ma. was usually passed for a period of two minutes, tranverse passages being made. The operations, in most instances, were repeated twice a week. The nodules became red, somewhat swelled, and slightly tender. Subsequently to the third or fourth applications shrinkage began to take place, and the nodules in many places disappeared, leaving only superficial cicatrices.

In cases of polypus, villous papillomata, warts, external hæmorrhoids, and other superficial developments, I have frequently found equally beneficial results, and in cases of nævus, of the superficial type especially, the effects have sometimes been startling.

In conclusion, the cases cited are merely examples of the many purposes for which I have employed the continuous current, and where, in the hands of practitioners, whether in America or at home, unpleasant results, such as inflammations or disappointing factors of other kinds have supervened, I am compelled by the experience of many years to think that there must have been something wrong in the apparatus employed or in the manner of using it. I trust that other medical men may be at least inclined to give a fair trial to a therapeutical agent of vast possibilities, cleanly, practically painless, and very largely efficient, easily portable and capable of approximately accurate measurement.

THE FAMILY CARE OF THE INSANE:

WITH REFERENCE TO THE PROBLEMS WHICH ARISE IN IRISH LUNACY ADMINISTRATION.

By CONOLLY NORMAN, F.R.C.P.I.,
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The family care of the insane, the care of the insane in private dwellings, either their own homes or the homes of others, was formerly subjected to a certain discredit on two grounds, one solid, the other nebulous. The solid ground is that in the early stage of most acute cases of insanity, the separation of the patient from familiar surroundings, his isolation in an entirely new *milieu* is an essential point of treatment. The nebulous ground is that some mode of family care was the earliest method of caring for those who are not able to care for themselves. Unorganised these modes were, and quite unprovided with any safeguards, or any machinery for the protection of the afflicted, should charity and patience fail and the ruder and more primitive instincts assert themselves among the custodians against the higher but often evanescent feelings that find satisfaction in self-sacrificing devotion. Accordingly these primitive methods, followed in unsuitable cases and followed quite without system, led to shocking abuses and scandals. Then came the time of the erection of asylums, which were to put an end to all these, and family care grew to be regarded as old-fashioned and barbarous. But it has been forgotten that the fact that a thing is old is not a necessary proof that it is bad. Nay, asylums themselves having grown old are now somewhat out of fashion, and are threatened with being looked upon presently as a hoary abuse.

Considered dispassionately, as all such questions ought to be, and without regard to unessential things or the whims of fashion, it must be obvious that asylums for the unsound of mind, under whatever name these institutions may be known, will always be required. It is true that it may be held that an asylum is not a necessity in any case where there is enough of money. Money can provide many things, even a changed *milieu.* But for many cases there rarely is enough of money. It might be said in the same way that except for the purposes of teaching there is no absolute necessity either, save a money reason, for the existence of a surgical or an obstetrical hospital. So with an asylum, but this qualification must be borne in mind, that mental disease is the most surely pauperising agency we know. Another matter which must never be lost sight of is the tendency to chronicity in course of an immense number of cases of mental disease which is symptomatically acute. Asylums, then, in some form are inevitable.

Asylums, themselves have often been shown to need a high organisation, a careful supervision, and a vigilant inspection. In the earlier times of their existence their management was disfigured by unjustifiable views as to the therapeutic advantages of repressive measures in dealing with the insane, and by ignorant and prejudiced notions as to the dangers that would follow from milder treatment. Owing, I may say, solely to the exertions of members of our profession, to the humanity, knowledge, zeal, and courage of devoted physicians, the bad old ways have been deserted, the old barriers of hatred and error have been broken down, and the history of modern benevolence and advance shows few brighter pages than those which deal with the improved methods in the care of the insane.

In recent years the old-time prejudice against the insane is seldom evident in its crudest form. When society, more perhaps with a view to its own safety and comfort than through any particular interest in the victims of insanity, had insisted on the construction of numerous special buildings for that unhappy class, it turned for a while its hatred on the people who looked after the insane. This feeling is possibly even yet not altogether extinct, and there is some tendency in certain quarters to hold responsible for the very existence of insanity and for all the troubles that it brings with it those who alone have introduced humanity and science into the refuges for the afflicted. Now, however, that the registered persons of unsound mind have become (either through the action of accumulation, or from other causes) so numerous a body that their support is a heavy drain on the finances of the country, public feeling is again turned towards the "lunatic" with uneasiness and dread, and it is beginning to be dimly felt that mere forcible language about alienists is no remedy.

The present seems therefore an appropriate occasion to consider whether, consistently with humanity, anything can be done to relieve society in this poor country of some portion of the burden which the ever-increasing number of the insane to be provided for places upon it. In looking into this question at this juncture, whether one contemplates it from the point of view of the ratepaper or from that of the physician anxious for the best interests of the most pitiable of all the sick, one cannot avoid giving attention to the subject of family care for the insane which has of recent years attracted world-wide attention, and is a topic that surely promises to present itself for consideration in the future, whenever the general treatment of the insane shall be under review.

In order that we may see whether family care is a mere pious aspiration, entertained by inexperienced but good-natured people, to whom its promise of greater freedom for patients is attractive, or by sordid individuals who think of nothing but reducing the rates at any cost in higher things; in order that we may not be led away into advocating what is after all only at best a hopeful experiment, let us examine what has already been done in this direction. It is only possible in the limits at our disposal to dwell on the records of family care superficially, inasmuch as the mass of material on the subject is now so great that even an epitome would be of vast size.

In two localities family care is of long standing and there in its modern form may be described as a development. In Flanders the insane colony at Gheel grew up ages ago round the shrine of Saint Dymphna which had become a place of pilgrimage. The old colony is of singular interest and will long remain attractive to the historian of humanitarian effort in the psychiatric field, but for our present purpose is less instructive than more modern instances and is chiefly of value as showing how local and special conditions can be developed to meet more general requirements, and as demonstrating the need that exists in all institutions for the insane of a strong central control. About the middle of the last century Gheel was full of abuses, and reform in the direction of methods which were then comparatively new, methods of non-restraint and of medical care, were urgently needed. These reforms were carried out, and Gheel was long a model of the family care colony, until at last it has been paralleled, if not distanced, by newer institutions which, though founded on Gheel, are more useful as examples having been initiated in modern times on modern lines.

Scotland, though the history of family care in that country is neither as old nor as illustrious as in Flanders, presents also a remarkable example of an old and very defective, one might even say very bad, system, reformed, organised, developed and improved up to a high standard of efficiency. Just as the Scotch Asylums, now the foremost in the United Kingdom, were extremely defective in the times before the reforms which followed on Miss Dix's revelations, so in the early days when public attention was first drawn to the Scotch method of "boarding out" the insane, there was little good to be said for it. The genius of Sir Arthur Mitchell, however, saw the possibilities of the system when reformed. His book on "The Insane in Private Dwellings" gives a rather terrible account of the state of affairs when the Scotch Lunacy Commission first took up the subject, and it was due to his energy and talent for administration that during the latter years of his official life he was able to point to the reformed Scotch system as an example of advanced and humane treatment. This it undoubtedly remains, though it may not meet with our unreserved approval in many details.

Some years ago the present writer endeavoured to draw the attention of the medical profession and the public in Ireland to the advantages of the family care of the insane. Nothing came of the attempt, but since then this method has been adopted in the Walloon country in Belgium, in France, in Germany, in Austria, in Holland, in Russia, in Italy, in Denmark, Norway and Sweden. Thus in our own day and in countries that are in the van of humanitarian, scientific and economic work, the method has been deliberately accepted. Everywhere the history of its progress has been the same. A certain degree of opposition has been offered. In some localities, where this was due solely to ignorance, prejudice, and terror, it soon vanished. In others, where the vested interests of non-medical owners of asylums seemed to be interfered with, the opposition was of a more lasting kind, but in every place system has withstood attack, has steadily gained popular favour, has secured official commendation, and has come to be regarded by the most advanced alienists as the crowning structure of the great edifice of non-restraint.

There are now in family care at Gheel between 1,850 and 1,900 patients; at the Walloon Colony, Lierneux, in the province of Liège, between 450 and 500; in Scotland over 2,650; in France, at the colonies of the Seine department (Dun-sur-Auron, Ainay-le-Château, &c,), about 1,500; at Berlin about 500. Elsewhere in Germany the numbers are difficult to ascertain, for where family care has been adopted in that empire it is conducted in each case from the local asylum as a centre, and there is no common report like that of the Scotch Commissioners showing what is done throughout the country. The numbers, however, must be very considerable, since family care has been adopted in connection with about forty different asylums. Some fourteen months ago a paper on the insane colony at the village of Gardelegen in Saxony, written by Dr. Wickel and translated by me, appeared in the Medical Press and Circular. At that date the numbers of public patients maintained in family care in the province of Saxony was 350 (as will be shown below it is considerably higher now). Gardelegen was opened to patients in the autumn of 1898 and in less than six years had attained to an insane population of 142, drafted from the single asylum of Uchtspringe, which was built to contain 1,000 patients. Besides these, 62 patients were then boarded out from the same asylum in a village built for the accommodation of married attendants close to the asylum, and in certain neighbouring villages. Thus, the central asylum (Uchtspringe) was actually relieved of more than 20 per cent. of its population. Furthermore, round the new asylums at Jerichow 146 patients were in family care in neighbouring villages.

Throughout the entire German Empire the numbers provided for in this way must thus be large, but owing to the nature of their distribution the statistics are difficult to collect. Similarly, with regard to

Austria, Holland, and Italy. In these countries also family care is administered from local asylums as centres. It is worth recording, however, that the latest public asylum erected in Lower Austria, a magnificent structure, in entirely detached blocks and constructed with every modern improvement, has been provided with an attendants' village in which each cottage is to contain three patients as well as the attendant and his family. The entire design of this asylum is to serve as not only a first-class modern hospital for the insane, but also as a centre for the establishment of an extensive family care colony in the district. This was adopted in a perfectly deliberate way by the provincial authorities after they had fully investigated the family care system in Germany, France and Belgium. In Italy among the asylums which have adopted the practice of family care is the famous institution at Reggio-Emilia, near Modena, which is probably the foremost asylum in the world for industrial occupation. (*a*) Its director, Dr. Tamburini, so well known for his scientific work, is an enthusiast for family care, and at the International Congress for the Care of the Insane held at Antwerp proposed the following resolution, which was unanimously adopted :—

"The Congress expresses the opinion that family care should be made use of in all its forms and in the largest possible measure."

It is evident from what has been said above that organised family care of the insane has been extensively employed of late years in some of the most advanced countries in Europe, and that several thousand patients are at present thus dealt with. Furthermore, it is possible at a very large and widely representative meeting of asylum physicians to obtain a unanimous expression of opinion in favour of this method.

As the subject is unfortunately still new in this country, it is worth while inquiring what is claimed for family care and how far it can be held to fulfil these claims.

The following is a brief statement of what the most advanced modern authorities claim :—

"For a very considerable number of the insane who need public relief, and who are suitable for this form of treatment, family care offers the method which is the most natural, the freest, the best, and the least costly, and which, furthermore, constitutes for many patients an important therapeutic factor.

"Family care can be employed round every asylum which is superintended by a mental specialist.

"Its application is probably limited in connection with large asylums, however, and it can best be carried out in country places round a small asylum of the hospital type.

"Family care cannot be used as a substitute for asylums, not being suitable for all cases, but it is a valuable method of preventing the constant enlargement of these establishments."

The above is a somewhat abridged translation of the resolution proposed by Dr. Alt at the Antwerp Congress, endorsed by all the German and French members, and adopted by a great majority.

Taking the first sentence, the phrases "most natural" and "freest" scarcely admit of any dispute. Nothing is more unnatural than an asylum, and, of course, the old-fashioned objection to family care used to be that it is too free. That it is the "best" method "in suitable cases" is scarcely more disputable ; but, of course, a fallacy may lurk in the notion of suitability. The number of cases that have proved suitable, as judged by experience, is much higher than would be supposed *à priori*. Suitability may be tested in various ways. The mortality in family care is about half that in asylums. This is very remarkable because in all insane settlements and among all patients in family care the prevailing form of mental trouble is chronic dementia and the general frailness of chronic dements and their liability to all kinds of intercurrent affections are well known. Besides, in some settlements—the French, for example—there is a great preponderance of senile cases. The dread of accidents of all sorts has always been a nightmare to those who opposed family care, but accidents are on the whole much rarer than in asylums. This is, of course, as it ought to be, since it is obvious that dangerous cases should not be selected for this mode of treatment, but no doubt much is also due to the soothing effect of a happier and a freer life. It is the old story of non-restraint over again. The responsibility of those who abolished mechanical restraint was grave, their courage high. On all sides they were met with warnings of the danger they ran and even threats of consequences therefrom. But no one now fails to see that though it might sometimes happen that restraint would prevent some individual accident, yet on the whole accidents are incomparably fewer since restraint has been abandoned, and the path of humanity was in this case the way to safety. Of course, the greatest security against accidents is that cases shall not be committed to family care until they have been thoroughly studied by capable experts and a fairly trustworthy opinion arrived at as to their tendencies. Where this has been done, as in certain places in Germany, it may be said that accidents are unknown in family care. One of those painful events which are called sexual accidents, is rarely recorded in the Annual Report of the Scotch Commissioners, but it is a remarkable fact that this is almost always a case of an imbecile girl boarded out in charge of her mother. Putting aside the question of whether the patient's immediate relatives are the best persons to take charge of him or her, I am of opinion that the Scotch system is rather too haphazard. The patients have often had no skilled observation before being placed in family care, and arrangements for inspection and supervision are not perfect. Under the highly organised and skilled system of family care initiated by Dr. Alt, about nine years ago, providing at the end of the year 1904 for 563 patients (about 14 per cent. of the insane in the province of Saxony), no serious accident or alarming or lawless event of any kind appears to have occurred. This is a record which it is to be feared no asylum can match.

It is evident, then, that danger is not the bogie which the older opponents of family care deemed it. We may be confirmed in this conviction when we observe that though this method has always been looked upon with apprehension by any population that knew it not, yet whenever it has been established it has grown rapidly popular and has remained popular. The popularity of family care contrasted with the permanent unpopularity of asylums, one of whose functions is commonly supposed to be to safeguard the public, is a curious but unmistakable evidence that the danger of family care must be very small.

Another test of the worth of the system in suitable cases is the expressed feeling of the patients themselves. It would seem that the patient is yet to be found who having been transferred from an asylum to family care asks to be returned to the asylum. It is not that they do not beg to be sent to their own homes just as the inmates of asylums do, but they never request to exchange the imperfect freedom of the settlement or the cottage for the more restricted liberty of the asylum. Considering the many amenities provided in a modern asylum this is strong proof that family life has a charm which institution life never can have. Besides the subjective side of the patients' emotions, the objective may be considered. It is a universal remark that patients in family care are on the whole less discontented, more cheerful, and more interested in their surroundings than patients in asylums. This, to be sure, is what might have been anticipated. For chronic patients who are not dangerous the dull monotony of an asylum must tend to stifle both emotion and intelligence. Atrophy from disuse occurs in the psychical as in the physical constitution. Recoveries are not rare in insane settlements, and that although the vast majority of patients sent to such places are supposed to be "incurable." In practice it would probably be found useful

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(a) In his valuable paper read at the International Congress for the Care of the Insane, held at Antwerp in 1903, Professor Tamburini mentions that among the rate-supported insane in Italy at that date 2,115 were provided for in family care.

to send many cases of doubtful curability into family care if this were carried on in connection with the asylum. It would afford a more organised system of probation, and give an opportunity of judging how far a patient still unrecovered can safely be trusted with entire liberty. Bearing out this idea, a fair number of patients have been recorded from various centres who, having been placed in family care, became after a while capable of supporting themselves and were removed from the list of beneficiaries of public charity, though they have not been recorded as cases of recovery. With a highly developed system of family care I would look for important therapeutic results, either cure or improvement, in many cases.

There is another feature in the family care method which may be of enormous importance. The overcrowded state of all our public asylums does much harm. The huddling together of vast crowds of people anywhere is demoralising ; the crowd is apt to take its tone from its worst and not from its best elements. In an asylum it is specially so. The insane require more elbow-room than ever can be provided in the crowded wards of our asylums. Again, where such huge numbers are to be dealt with, individual treatment, the only reliable means at our disposal, becomes impossible. It is probable that the vast accumulation of the insane which occurs in our larger asylums is injurious from every point of view. In asylums miserably undermanned medically, as all our asylums are, the result is quite disastrous. It is impossible to give the cases that might get well that study and care which they need. Recovery or even betterment is often thus impeded or lost, and the vicious circle goes on without end. It is universally felt that our asylums should be smaller, better equipped, and better manned. To get rid of a considerable percentage of the more chronic cases seems to be the first step towards getting the institution into a more manageable size, so that time and strength and energy may be given to the cases which demand the expense of these things, cases that can benefit from the most individualised methods, cases that will reward the study bestowed upon them, and justify the care taken to avoid complete deterioration and that lamentable subsidence into dementia which is so apt to be the goal of uncured mental disorder. It is true that another method has been suggested for dealing with a number of the chronic cases that encumber our asylums, namely, to remove them to workhouses, where they would cease to receive any care at all, but that to me seems to be very contrary to modern humane ideas in such matters, and I cannot think it would prove either safe or permanently feasible.

On the other hand, family care presents a practical, well-tried, and commendable means of relieving asylums of a considerable degree of over-crowding and thus freeing the energies of those institutions for their special work. This means may fairly be called a development of the humane methods of non-restraint, enlarged freedom, and wholesome occupation for patients, which it is the glory of modern psychiatry to have advanced in spite of the opposition of every sort of ancient prejudice.

(*To be continued.*)

THE
SURGERY OF THE STOMACH.(*a*)

By J. E. GORDON, M.D., F.R.C.S.,

Surgeon to the Adelaide Hospital, Dublin.

IN this survey of the surgery of the stomach I will confine my remarks to the treatment of non-malignant disease. I have, indeed, only once attempted resection of part of the stomach for cancer. In that case the patient lived almost three years after the operation.

In dealing with non-malignant disease, I can pass over much which, formerly matter for controversy, has now passed into written law.

Perforated ulcer.—There has been some difference of opinion concerning technical details in operating for perforated ulcer, some favouring evisceration and douching, others relying on dry sponging. I have myself adopted the former method in four operations which I have performed during recent years ; of these, all recovered except one, and in that case, since the operation was delayed until forty hours had elapsed from the time of perforation, the failure cannot be assigned to the method employed. Other surgeons have had equal success without eviscerating or douching. Thus the question does not appear to be one of vital importance. It has been objected that the copious washings are likely to induce subsequent adhesion. In one of my four cases, I found it necessary a year later to re-open the abdomen to perform a gastro-enterostomy, and I found it free from adhesion.

Gastrectasis due to simple pyloric stenosis.—It may be equally brief in reference to gastro-enterostomy as a treatment for stomach dilatation due to simple pyloric stenosis. I have had, in common with most operators, a considerable experience of this class, and the general good results obtained have led physicians to regard these cases as purely surgical. There is, therefore, no necessity to recite particular instances in defence of the operation, and even respecting details of method there is a remarkable unanimity of opinion. No doubt, some of the best surgeons still employ buttons, but by the majority among us these have been discarded for simple suturing. Even with regard to the time factor, which is often important, there is little if any advantage gained by the use of these appliances. I have, where minutes had to be considered, completed the entire operation in twenty minutes, and that without dangerous haste.

Gastric hæmorrhage.—In gastric hæmorrhage, there is more room for debate concerning treatment, but I shall not say much about it because my experience has been very limited. I saw with Dr. Peacocke an extremely anæmic girl, who was brought to the hospital on account of repeated and severe attacks of hæmatemesis. She had for some years been under treatment for gastric ulcer, of which the symptoms had been recurring attacks of severe stomach pain and vomiting. When we saw her she was so extremely weakened by loss of blood that we decided to delay operation. I operated after about a fortnight, and on exploring the stomach I could feel a large ulcer on the posterior wall near the lesser curvature. Posterior adhesions made the gastro-enterostomy difficult, and not entirely satisfactory. However, she had materially improved when she went to the country some six weeks later, and there was no further hæmorrhage. She is now in excellent health.

Two facts stand out clearly relative to these cases of recurring hæmorrhage. One is that such hæmorrhage is directly dangerous to life ; the second that operation, generally gastro-enterostomy, has proved successful in a majority of the cases.

The treatment of chronic ulcer.—The case I have just cited will serve to introduce a difficult problem—the surgery of chronic gastric ulcer itself, *i.e.*, apart from its complications. In discussing this problem, I shall exclude reference to choice of operation. When I speak of surgical treatment

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(*a*) Paper read before the Surgical Section of the Royal Academy of Medicine in Ireland, November 3rd, 1905.

I mean posterior gastro-enterostomy. The solution of the problem is to be arrived at by a consideration chiefly of three things: First, *surgical experience* as regards ultimate result; secondly, *medical experience*—the prospect of cure without resort to operation; thirdly, *relative risk*—the risks of perforation or fatal hæmorrhage in cases treated medically as compared with the risks of operation.

1. *Surgical experience.*—Among my own cases, I have given one in which the result has so far been satisfactory. Another, a young girl, was placed under my care by Dr. Little. She had suffered from stomach pain for twelve years, had vomited blood on several occasions, was much emaciated, and had been confined to bed for nine months before she came to hospital. As the results of operation, this girl is now able to get about, can take her food, and has put on weight, *but* she still suffers from pain. There are, however, some reasons for thinking that the pain in this case is due to adhesions.

My personal experience is not large, but general experience seems to clearly prove that a cure may be anticipated in a majority of cases operated upon for chronic ulcer.

2. *Medical experience.*—Now what is to be learnt from the experience of physicians? With the assistance of the then house-surgeon, Dr. Carter, I investigated the cases of gastric ulcer which had been treated in the Adelaide Hospital during the past five years. We wrote letters asking these people certain questions, with regard to pain, for instance, and in the majority the answers were decidedly unsatisfactory; very few appeared to have been cured of their symptoms. Moreover, all the cases which we have operated upon have been treated medically for years. I think it must be conceded that medical treatment is likely to fail in a majority of hospital patients, at all events.

3. *Relative risk.*—I shall now ask you to consider the question of relative risk. I am confident that fatal gastric hæmorrhage and perforation are more common, probably much more common, than was at one time thought. During the past three years I have known of at least three people who died as the result of recurring gastric hæmorrhage. I have referred to four cases of gastric perforation which came under my own care during the past few years, and I am sure others have met with many more than this. We may, then, fairly assume that these catastrophes are not uncommon; that the risks attending chronic ulcer of the stomach are very real. At the same time, I am convinced that relative to the vast number of cases of gastric ulcer which occur in these countries, the catastrophes are uncommon, and despite the apparent teaching of large hospital statistics, I believe that the risks have been altogether overestimated. This cannot be said concerning the risks of operation, and yet I know that these also are very real. I have only had one death as the result of gastro-enterostomy for non-malignant disease; the cause of death was hæmorrhage. That is a very rare accident, but I am sure I am not alone in this misfortune.

In another case a different accident occurred which might have proved fatal, but, fortunately, the patient recovered. This case was one of well-marked gastroptosis and consequent gastrectasis. I performed a posterior gastro-enterostomy, and a few days later re-opened the abdomen on account of persisting regurgitant vomiting. I found that an internal hernia had taken place; a large amount of small intestine had passed beneath the anastomosis from right to left—not, please note, into the lesser sac, which is a less uncommon accident. The bowel at the anastomosis was reddened and distended, whilst that which had passed under the anastomosis was contracted. I reduced the hernia and the patient recovered, but I fear the hope of ultimate perfect recovery is small.

The narration of these two misfortunes is sufficient to enforce my point—that gastro-enterostomy is attended with risks to life. I may further observe that it has lesser risks which, though not affecting life, may materially modify the ultimate success of the operation. I have in mind the possible formation of adhesions due to some error, perhaps unavoidable, in aseptic technique. I once operated upon a lady, who had suffered from gastric pain and other symptoms for many years, and found an extraordinary degree of deformity of her stomach, the result of previous ulceration and associated with adhesions. The stomach was so bent upon itself that the pylorus was drawn close to the cardia, and the lower curvature was practically non-existent. There was a broad area of fibrosis running across the anterior surface, a dilated pyloric antrum, and a narrowed pylorus. I made a gastro-enterostomy on the cardiac side of the fibrous area, although this side was not dilated at the time. Good was done for a time, but within a year the patient's sufferings were much as before the operation. I re-opened the abdomen and found an extensive formation of adhesions and a dilated gall-bladder. I freed these, especially about the gall-bladder, and the patient is now in good health.

It is the danger of this formation of adhesion which makes a rigorous asepsis so essential in these operations.

I have dwelt thus at some length upon these possible defects or dangers of gastro-enterostomy because, as I have hinted, I think there has been, of late, a tendency to slur them over. At the same time, I gladly allow that accidents are decidedly rare. In the large majority of cases recovery is quite uneventful. One can generally count on having the patient able to leave his bed on the sixth or seventh day, and to go home at the end of a fortnight. The fact is, that as with medical treatment so with surgical, the number of fatalities is small, but more, many more, gastro-enterostomies must be performed for chronic gastric ulcer before one can decide to which belongs the greater risk. On the other hand, the ultimate result—the prospect of cure—is infinitely greater with, than without, surgical intervention. I shall not attempt to follow out the solution of this problem further, but permit me to point out that the balancing of risks is, after all, only one factor, for the pain, the chronic ill-health and consequent incapacity for work are, under certain circumstances, matters equally important as life itself.

Gastroptosis.—I will conclude my paper with a description of a different class of case, which has not been so widely discussed as the others, *i.e.*, gastroptosis and gastric neuroses. Gastroptosis is by no means necessarily associated with a neurotic state. I saw four or five years ago a middle-aged woman who had a freely movable right kidney and a dilated stomach. I fixed her kidney.

About a year ago she came again to me owing to a return and increase of her stomach trouble. At the operation I found what appeared to be a tumour at the pylorus. I performed a posterior gastro-enterostomy, and soon afterwards reopened the abdomen with the intention of excising part of the stomach, but the tumour had almost entirely disappeared! This patient wrote recently saying that she was in excellent health and free from her former distress.

Gastroptosis is, however, more frequently associated with a neurotic state, but the relation between them is not always the same. We may, I think, recognise two distinct groups. In one the gastroptosis is primary and has induced a neurotic condition in a predisposed individual, in the other the neurosis is primary and the gastroptosis is but a manifestation or result of the general muscular hypotonus, which is so striking a feature of neurasthenia.

That a disordered stomach may cause a disorder of the mind is a matter of common experience, but let me give an example. I saw some time ago a young man who for years had suffered from stomach disorder. He, so to speak, lived for his stomach, and gave up all manner of amusements. He was advised to ride a horse, and did so for his stomach's sake, and gave it up because it seemed to make him worse. He took his stomach for a trip abroad and brought it back as bad as ever. He gave up work in college and devoted his mental powers, which were above the average, to thought about his stomach. He consulted many doctors, and received every conceivable treatment—Weir Mitchellenis, electricity inside and outside of him, and I know not what besides. All with no effect. I found he had a large dilatation of his stomach with much splash, but there was no visible peristalsis. I performed a gastro-enterostomy, and since then he has improved in a striking manner. He has resumed his college course, takes an interest in the world again, and will, I have no doubt, become a useful member of society. The result in this case seems to show that the gastrectasis, not the neurotic state, was the primary fault. As a fact, at the operation I found evidence of inflammatory changes, for the wall of the stomach was remarkably tough and there were posterior adhesions. My interpretation of the case is as follows:—I believe that the disease had its origin in an attack of measles, which immediately preceded the development of stomach symptoms. This may have caused a catarrh of the mucous membrane, and possibly a loss of muscle tone. As a consequence dilatation began. This, in a person with strong neurotic tendencies, induced the general neurotic state, which, once established, tended to perpetuate the atonic dilatation, and thus a vicious circle was established.

In this case, gastrectasis, not gastroptosis, was the exciting cause of the neurasthenia, but I wish to suggest, as a general law, that operation is legitimate, and has a good prospect of curing a neurotic state if there is reason to believe this due to stomach ptosis or dilatation, *i.e.*, if the stomach lesion has preceded the neurotic symptoms.

As regards the second group, in which the gastroptosis is merely a part of a general nervous fault, I believe that operation is useless. I have had such a case under my care; I performed a gastro-enterostomy, and it has been a failure.

And now, gentlemen, I have kept you much too long. I hope what I have said has been of sufficient interest to arouse your criticism.

Clinical Records.

THE FRENCH HOSPITAL, LONDON.

A Loose External Semi-lunar Cartilage—Operation—Recovery.

Under the care of Mr. EDMUND OWEN, F.R.C.S.,
Surgeon to the Hospital.

[For the Notes of this Case, we are indebted to Mr. Dudley Kennard, House Surgeon.]

A French shipwright, æt. 19, was admitted into hospital at the beginning of last June, on account of swelling and pain about the right knee. He said that six months before, whilst carrying a weight, his right knee had suddenly given way, and he had fallen, and that the same thing had happened without any warning several times since. Each time that the knee gave way he fell; on two occasions the knee was left rigidly bent, and he had to be taken to a hospital and placed under an anæsthetic before it could be got straight. He went on to say that the trouble in his knee gave him a constant feeling of insecurity, and made him unfit for carrying on his work. That on each occasion the knee had given way he had afterwards been laid up for a while with swelling and pain, and that he was anxious to undergo operation if it would give him a fair promise of getting a trustworthy joint once more.

At the time of his coming into the hospital there was fluid in the joint, and pressure with the finger between the front of the outer condyle of the femur and the external tuberosity of the tibia showed the tender spot. Mr. Owen operated on the man on June 9th, removing the loose part of the disc.

Remarks by Mr. Owen:—Although I have operated upon a considerable number of cases in which the *internal* semilunar fibro-cartilage had become deranged, this is the first occasion on which I have been called upon to operate for the removal of the external one. Indeed, I have seen but very few cases of a deranged external cartilage. Why the external cartilage should so generally escape injury I do not know, unless it is that, being less firmly fixed to the head of the tibia than is the internal one, it is generally able to glide out of the way, and thus avoid a blow, shock or squeeze such as would have been enough to split or detach the other.

When I opened the joint (through a vertical incision down the outer side of the patella) I could not for some time find the external semilunar cartilage, and I wondered what had become of it; but at last I discovered it lying right across the outer articular facet of the tibia, a long way behind its proper situation. Having tightly got it in the grip of a pair of clip-forceps, I pulled it well forwards and cut away as much of it as I could reach. So far as my experience goes, it is impossible to remove the whole of a semilunar cartilage, for the posterior part is quite inaccessible behind the condyle of the femur. Fortunately, experience shows that it is not necessary to remove the whole of the disc, it is only that part which has been violently thrust across the articular surfaces, and is thus hindering their smooth working, which needs to be taken away. It is probably better to cut away the front part of the cartilage than to content oneself with the more conservative plan of stitching the displaced cartilage in position, as any further injury to that part of the knee would be more than likely to break through the stitching and cause fresh displacement. On the other hand, experience has amply shown that a man need suffer no inconvenience whatever after the removal of a semilunar cartilage, men—and women—on whom I have operated being fully as active after the operation as ever they had been before it. And in a large proportion of the cases of the people with a slipping cartilage in the knee the habits have been unusually active.

I need hardly say that every case of slipping cartilage does not need an operation. A great deal may be done for the person by fixing the limb in a cage-like splint which allows only fore-and-aft movements. It is the outward twist of the leg which the patient so much dreads, as in a sudden turn, or as in ever so slight a knock to the inner side of the great toe when the leg is partly bent, and the foot loosely pointed outwards. The cage-splint may have the effect of making him quite comfortable and secure, and it need not interfere with the enjoyment of a reasonable amount of athletic exercise.

As often happens, a good deal of bleeding took place into the joint after the cutting across of the cartilage. This was dealt with by swabbing with long strips of aseptic gauze. Irrigation was not used. The synovial wound was closed separately, a drainage tube being left in for twenty-four hours. The limb was fixed upon a splint with a foot-piece with the knee very slightly bent. About three weeks after the operation the man went down to the French Convalescent Home at Brighton, and on his return to London he reported himself to Mr. Kennard, who found the knee strong and trustworthy, and the man greatly pleased with its behaviour.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

Meeting held Friday, November 24th, 1905.

The President, Mr. Clutton, in the Chair.

Dr. Samuel West described a case in which the

PLEURA CONTAINED SEVERAL PINTS OF CALCAREOUS MORTAR-LIKE FLUID.

A man, æt. 32, was sent into St. Bartholomew's Hospital with the diagnosis of empyema; the whole left side of the chest was dull. Except for lateral curvature with the convexity towards the right, the patient was well developed and well nourished. Exploratory puncture obtained a white fluid like Devonshire cream in appearance and consistency. This contained very little fat, no trace of cells, and was chiefly composed of lime salts (phosphate of lime). Paracentesis withdrew only an ounce or two more. It was decided not to open the side, as the lung must be completely bound down and useless. The pleura was tapped in various places, but always similar fluid obtained. The patient remained well for three weeks, then developed bronchitis and died after a few days' illness. It was learnt subsequently that his doctor had known of the existence of fluid in the left side for twelve years. *Post-mortem.*—The left pleura was found to contain about four pints of white mortar-like fluid; this formed a thick lining to the pleura, in places half an inch thick, containing numerous flat calcareous plates, a few adherent, but most of them detached. The left lung was completely destroyed, nothing remaining except a little pigmented fibrous tissue round the bronchi. The fluid, pleura and lung were carefully examined for tubercle bacilli without success. The spinal column was curved, but there was no disease of the bones. There were no signs of tubercle in any part of the body. Analysis of the fluid showed that it consisted of equal parts of lime salts and organic residue, the latter was composed of fat and cholesterin chiefly, and a heterogeneous residue. Presumably the fluid arose from a degenerate empyema. The case was believed to be unique.

The President commented on the close resemblance borne by the material to that found in old tubercular abscesses, such as those in the psoas. In these cases, as in the present one, it was frequently impossible to find any certain evidence of tuberculosis, though doubtless this was the original process.

Mr. A. E. Barker asked whether inoculation experiments had been carried out in this case to investigate the point.

Dr. West regretted that these had not been done.

Dr. Samuel West also read a paper on

PERIODIC RESPIRATION.

Periodic respiration is the name given to the breathing when it occurs in regular phases. There are two special forms of it:—(*a*) Cheyne-Stokes breathing, and (*b*) grouped respirations. The characters of Cheyne-Stokes breathing are:—1. Groups of respirations separated by long pauses. 2. The gradual crescendo and diminuendo of the respiratory movements. 3. The rapid rate of breathing while it continued might be at the rate of 120 in the minute. The characters of grouped respirations are:—1. Groups of two, three, or four respirations. 2. Equal depth of the individual respirations, *i.e.*, no crescendo or diminuendo. 3. Of slow rate, not more than 8-10 in the minute. Cheyne-Stokes breathing may be met with in central nervous affections, cerebral or bulbar, when the patient is moribund, but is most frequent and characteristic with a failing left ventricle. In the latter instance it is of fatal omen, even when there are at the time no other alarming symptoms. In the former the patient is dying of the disease, so that the phenomenon is of no clinical assistance. Grouped respirations are met with only in meningitis, and especially in the posterior basic form. In the latter case, if recovery takes place the phenomenon passes off, and it is again of no importance for prognosis. The two forms of periodic respiration are therefore strongly contrasted not only in character, but also in prognostic value. Tracings of the two forms were exhibited.

Dr. A. E. Garrod commented on the physiological variety of true Cheyne-Stokes respiration, and referred to an instance he had seen recently during the sleep of a man nearly ninety years old. And the cases occurring in heart disease, in these the fatal issue might occasionally be postponed for a considerable period, at least nine months. He thought that the uræmic cases, which doubtless Dr. West had included under the heading of nervous affections, merited a separate discussion.

Dr. Herbert French narrated the case of a woman, who died with no kidney lesion, but with an uterine sarcoma involving both ureters. She passed no urine for twelve days before death, and for eight of these she presented typical Cheyne-Stokes phenomena; there were no other symptoms of uræmia.

Dr. West, in reply, said that most of the instances in which Cheyne-Stokes respiration occurred in kidney disease, were cases of failing heart and not of uræmia.

Dr. F. E. Langmead (introduced by Dr. A. E. Garrod) gave an account of a case of

RELAPSING TETANY, ASSOCIATED WITH DILATATION OF THE SIGMOID FLEXURE.

The patient was a boy, æt. 6, admitted into the Hospital for Sick Children, Great Ormond Street, on five different occasions, suffering from tetany associated with the evacuation of porridge-like stools. He was discharged free from these symptoms after each stay in the hospital, lavage to the lower intestine proving successful when other treatment had failed. There was general abdominal distension and a hollow tumour could be made out in the left half of the abdomen. On the fourth admission hæmaturia was present. On the fifth the tetany was complicated by diphtheria, which proved fatal. *Post-mortem.*—The dilated viscus proved to be the sigmoid flexure, which was of very unusual dimensions. Two uric acid calculi were found in the right kidney. The interest in the case lay in the association of tetany (1) with dilatation of the sigmoid flexure; (2) with renal calculus. (1) Only one recorded case of tetany associated with local dilatation of the intestines could be found. The dilatation of the sigmoid flexure was probably analogous to the dilatation of the stomach described by many authors, and this bore on the etiology of tetany, since it showed that the stomach was not an essential factor. (2) Although no record of tetany associated with renal calculus could be found there were three such cases among the ten fatal cases of tetany in the *post-mortem* records of Great Ormond Street Hospital, whereas such calculi occur in only 0·57 per cent. of the general autopsies of the hospital.

The **President** said this paper furnished yet another argument for the necessity of operation in cases of dilated sigmoid. He referred to the importance of the condition in the production, in later life, of volvulus. Lateral anastomosis was usually preferable to excision, and often a preliminary drainage operation had to be undertaken. He suggested that the calculi might be due to the damage wrought through the excretion of intestinal toxins by the kidney.

Dr. **Ewart** had seen tetany in chronic intestinal obstruction, but not in cases of dilated colon.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

Meeting held Friday, November 17th, 1905.

The President, Dr. R. D. **Purefoy**, in the Chair.

The first business of the meeting was the President's Address. It dealt with the early history of the Obstetrical Society, which was inaugurated in November, 1838.

The Results obtained in the Treatment of Eclampsia in the Rotunda Hospital.

Dr. **De la Harpe**, by special permission of the Council, then read a paper on the above subject. He brought forward statistics of the hospital for the past thirteen years. These have not been published before, and consist of a series of seventy-one cases treated by morphia injections, and exclusively palliative measures. Twelve died, a percentage of 16·9 results which have never before been approached by any former published statistics of the hospital. He warmly advocated the more general adoption in practice of the Rotunda methods, which briefly consist of —(1) Injections of morphia up to 2 grains in twenty-four hours; (2) thorough lavage of the stomach by means of syphon-tube; (3) purgation by castor oil and croton oil combined, these being passed through the tube before its removal; (4) thorough lavage of the lower bowel; (5) keeping the patient lying on the side to prevent fluids formed in the mouth entering the lungs and causing the so-called œdema of the lungs to occur; (6) poultices to loins; (7) plenty of saline fluid to be administered through stomach and rectal-tubes, or injected beneath the breasts. No operative interference of any kind is considered advisable. Vapour baths and hot packing are not used; neither is nourishment given during the acute stage.

Sir **Arthur Macan** remarked that the treatment by morphia was well known to him, even before Dr. Smyly was Master of the Rotunda. One reason why he did not adopt the morphia treatment was that he was satisfied with the results obtained by the treatment used while he was Master. This was a big turpentine enema, and chloroform to begin with, followed by chloral hydrate per rectum, as much as ʒii in three or four hours. The sweating treatment was not much used, but since then he had used the hot-air bath with very satisfactory results. He thought that the profession almost universally recognised that the termination of labour was a very important point in the treatment. For the use of dilators, Cæsarean section, &c., all pointed to a belief in the efficiency of delivering the woman, and a non-belief in the efficacy of the morphia treatment.

Dr. **Horne** said that to compare statistics of twenty-five years ago with statistics of the last ten or fifteen years was very erroneous, owing to the advent of Listerism, owing to which the mortality had been greatly lessened. He would not like it to be laid down that there was any routine treatment for eclampsia. Every case had to be treated on its merits and its condition on admission. He related a case which had occurred in the National Maternity Hospital this year, remarkable from the fact that it commenced in the fifth month. He had hoped to have learned the cause of the eclampsia, but it was passed over in the paper by saying that it was due to an "auto-intoxication." No special form of treatment could be relied on, and we must be prepared to use morphia, or, in certain cases, Cæsarean section, vaginal section, Bossi's dilator, &c.

Dr. **Jellett** said he would have liked Dr. de la Harpe to have gone into the question of the operative treatment of eclampsia. He was in thorough accord with Dr. Horne that no fixed line of treatment could be carried through in every case, nor did he believe that any one theory or set of causes would be found which could be laid down as the cause of eclampsia. One class of cases would be found to be due to one set of causes, &c., and treatment could then be classified accordingly. He said he was interested in the radical treatment of eclampsia, principally owing to the fact that he had been represented by Dr. Herman, in a paper read before the Medical Society of London, as having recommended such treatment at a time when he was distinctly opposed to it. Since then, in view of more modern statistics than those quoted by Dr. Herman, he was inclined to look on this treatment with more favour in serious cases. He quoted some of these statistics. He would not argue that radical treatment was the right one to adopt in all cases, but he did think that there were grounds for taking it into consideration, and for considering whether in cases that appeared to be severe, the radical treatment of emptying the uterus should not be adopted from the start.

Dr. **Hastings Tweedy** considered it a pity that one line of treatment could not be followed, as the cases were few in number. So long as we believe that no hard-and-fast line of treatment should be followed, we would be working in the dark. No useful statistics could be compiled, and one could not say what was the best line of treatment to adopt. He believed that the infrequency of eclampsia in Dublin was due to the habits of the people. In hot countries people accustomed themselves to very little fluid, but in Ireland the women drank a good deal of tea, &c. As to causation, he did not think that our knowledge of treatment would be brought much forward by knowing what the poison was. We had fair grounds for saying it was a toxæmia in the system. We saw lots of toxæmia which fell just short of eclampsia, headaches, drowsiness, dulness, &c. He considered that the Master of any hospital should be very careful to include in his statistics every form of fit that came in, except epilepsy, as eclampsia.

Dr. **Neill** had seen a good number of cases of eclampsia in the Coombe Hospital. In one remarkable case the child was lying transverse, and as soon as the malposition was corrected the eclampsia ceased. The other cases were treated with morphia. Some of them were very bad, but all got well. Two or three minims of croton oil and vapour baths were given in every case.

Dr. **Gibbon Fitzgibbon** said that one point which had been largely ignored was the question of purgation. It was the treatment adopted in combination with the other palliative measures, and even in those cases where radical treatment was undertaken. In the morphia treatment a large amount of purgation was gone in for. The bowels and stomach were washed out, and sometimes up to 7 minims of croton oil were given to clear out bowels. Sinclair and Johnston reported a series of sixty-three cases occurring from 1847-1854. In those three or four were given among the recoveries which were probably epileptic. There were thirteen deaths, but a certain number were certainly due to septicæmia. In those cases the treatment practised for the first five years was free venesection, and large enema and purgatives were also given. In the last two years of that series venesection was continued, but the purgation was left out, and there was a considerably higher death-rate.

The **President** desired to add his quota to the praise already bestowed on the paper to which they had just listened. It was plain, from a study of the old Master's books in the Rotunda Hospital, that free venesection was the routine treatment of puerperal eclampsia for nearly a century after the opening of the hospital, and in many of the cases, even those admitted in coma, recovery took place. After the discovery of chloroform it also came into use, sometimes alone, sometimes combined with venesection. Dr. Atthill had recorded an interesting case in which chloroform produced no effect in mitigating the seizures till blood was drawn, and subsequent recovery ensued. No method of rapid emptying of the uterus, remarked the President, had ever commended itself to him, though firmly convinced of the wisdom of expediting delivery by any gentle methods available, such as the use of forceps when the head is easily within reach. He had tried venesection, sometimes alone, sometimes followed by intravenous saline injection, but without success, possibly because the patients were beyond the reach of any treatment.

Dr. De la Harpe replied.

Dr. Tweedy showed the following card specimens:—(*a*) Eleven myomatous uteri removed by abdominal hysterectomies; (*b*) myomas removed from three uteri abdominal myomectomies; (*c*) one myoma of cervix; (*d*) one cancer of body uterus—Wertheims' operation; (*e*) two cancers of cervix—vaginal hysterectomies; (*f*) one epithelioma of vulva; (*g*) four ovarian cysts; (*h*) two ovarian dermoids; (*i*) one ovarian cancer; (*j*) diseased tubes removed from four patients; (*k*) three tubal pregnancies.

The meeting then adjourned.

THE BRITISH LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL ASSOCIATION.

The Annual General Meeting of the above Association was held on Friday, November 10th, at the rooms of the Medical Society, at which Mr. Robert H. Woods, M.B., F.R.C.S.I., was elected President for the ensuing year. The retiring President, Mr. Chichele Nourse, received a most hearty vote of thanks for the way in which he had carried out his duties.

The following cases and specimens were shown:—

Dr. Wyatt Wingrave, a case of "Abductor Paralysis of Right Vocal Cord" in a male, æt. 58. There were symptoms of difficult deglutition, and gradually increasing hoarseness of six months' duration.

Mr. Clayton Fox considered that this case seemed to be one of gummatous infiltration of the œsophagus involving the recurrent laryngeal nerves.

Dr. Dundas Grant was disposed to attribute this paralysis to involvement of the right recurrent laryngeal in carcinoma of the œsophagus.

Mr. Chichele Nourse showed a case of "Laryngeal Neoplasm" in a man, æt. 37. This patient is rather addicted to tobacco and alcohol, has a growth the size of a small pea attached to the edge of the right vocal cord at the junction of the anterior and middle third. On attempted phonation it comes up between the cords and prevents them from approximating. At the same time the right arytenoid passes across in front of the left.

Mr. Bark suggested that this was a growth from the anterior commissure, probably a soft fibroma and of embryonic origin.

Dr. Dundas Grant observed some anomalies in the movements of the vocal cords, which he thought could not be explained merely by the mechanical obstruction produced by the growth itself. He thought there was some underlying disease, the nature h which would be revealed by the removal of the growt and its examination under the microscope.

Mr. Nourse, in reply, said, when first seen this patient's larynx was very intolerant of examination, but afterwards became less irritable, and it was then clearly seen that the attachment of the growth was the junction of the anterior and middle third.

Dr. Andrew Wylie showed a case of "Congenital Specific Disease" in a lad, æt. 15. He had been weakly since birth, fourteen months ago be became worse, at times great difficulty of breathing. In August he was sent to me to have tracheotomy performed. The soft palate was bound down to the pharyngeal wall by means of a cicatricial tissue; the epiglottis was nearly gone, the ventricular bands were swollen; movements of cords unimpaired; weight, 4st. 5lb. Slight cough, no tubercle bacilli. Father living, had ulcers on both legs; mother well; six children living, four died in infancy. The patient was treated for phthisis, but became worse. In September inunction of mercury and Donovan's solution internally was tried with great success; from the first day symptoms of dyspnœa gradually disappeared, appetite improved, breathing became more regular, cough less; weight now 5st. 6lb. I consider this a case of congenital specific disease which was not treated, and the patient becoming tuberculous, the symptoms became serious.

The President remarked that the successful treatment of cases of this kind sometimes presented enormous difficulties, especially in the ill-nourished and poor, and he thought the surroundings of the patient were of an importance quite equal to the medicinal treatment.

Mr. Dennis Vinrace asked whether the case was an illustration of congenital specific disease, in which no specific remedies had been applied, or whether it was shown to exemplify the result of anti-specific treatment?

THE INJECTION OF SOLID PARAFFIN.

Dr. Andrew Wylie showed a case in which solid paraffin had been injected into the nose without an anæsthetic. The case is a girl, æt. 19, who had distinct "saddle-nose." Paraffin was injected by means of Mahn's instrument in the solid state; an assistant held the head and pinched up the skin with his two forefingers. There was no pain; two weeks later a little more was injected. The advantage of no anæsthetic is that the patient sits opposite the surgeon, he can see what amount is required. The cause of so many failures is that too much is often injected.

Mr. Bark congratulated Dr. Wylie on the very successful result he had obtained, and he felt that the Society was under an obligation to him for showing this apparently easy method of performing subcutaneous injection of paraffin for the relief of saddle-shaped deformity.

Mr. Clayton Fox thought that one very important danger was eliminated by this method of injection with solid paraffin—*viz.*, embolism. Cases have been described where the arteria centralis retinæ had been thus involved.

Dr. Dundas Grant was able to corroborate Dr. Wylie's advocacy of the use of solid paraffin, and ventured to think that perfection had almost been obtained, more especially as the friable paraffin, such as Dr. Wylie had used, was not likely to form a thread in the puncture, as formerly took place with the non-friable forms of paraffin previously in vogue.

Dr. Vinrace said the question of an anæsthetic was not very material in such cases; but he thought it most desirable that these cases of injection of paraffin should be exhibited a year or two after operation, when permanent results could be estimated. He pointed out that the immediate result might be misleading to intending operators.

In reply, Dr. Wylie said he would endeavour to bring this patient and others next session to show the permanent result.

Mr. Stuart-Low showed two cases illustrating the "Retention of the Cholesteatomatous Lining in the Operation for Acute Mastoiditis," a sequel to chronic suppurative disease. He said he had shown these two cases, as they illustrated a new departure in the conservative surgery of the ear. There were few surgeons who had not been obliged to operate during an acute exacerbation in chronic cholesteatomatous conditions of the middle ear and its accessory cavities. Hitherto the usual procedure had been to ablate the mastold cells, and having exposed the antrum, to scrape away every vestige of the cholesteatomatous lining. This was not infrequently attended with disastrous results, especially from secondary meningitis, which is the most fatal form of meningitis. If the middle fossa was already exposed, however, either through the antral or tympanic roof, the danger of meningitis was increased exceedingly. With the view of minimising the risks the cholesteatomatous lining which was in each of these cases a very beautiful one, being firmly placed on the bone, smooth and shiny and quite complete, was left *in situ*. Dr. Dundas Grant had left the cholesteatomatous membrane in the surgical treatment of chronic ear suppuration, with good results. Regarding this change as a reparative effort of nature, Mr. Stuart-Low had ventured a step further, and left the lining in operating under these acute conditions. This was fully justified by the results, as the discharge had ceased and the hearing power was preserved almost entirely. The likelihood of either of these cases requiring a radical mastoid operation was very remote. The practical points were that, having scooped out all the putty-like cholesteatomatous material, and left the lining undisturbed, the operator must employ a 50 per cent. solution of rectified spirit to swab out the cavity, and gauze strips saturated with the same solution should be employed for subsequent packing and dressing.

Dr. Hutchinson did not consider the hearing power good.

Dr. Wyatt Wingrave considered the subject of cholesteatomatous changes in the middle ear required very careful clinical and pathological observation. That clear distinction should be drawn between a passive or primary cholesteatoma and that condition (the commoner one) which occurred as a process secondary to inflammatory condition—*i.e.*, an active desquamative process in which bacteria played such an important part; so long as the epidermising surface is kept dry, sterile and free escape afforded to the rapidly-forming squamous complications from the source were unlikely.

Dr. Dundas Grant considered that Dr. Wingrave had touched a very important question, namely, that of the difference between a cholesteatoma as a genuine new growth, and the so-called cholesteatoma resulting from the invasion of the epidermic epithelium into the cavities of the middle ear and mastoid, through a perforation. The former was very rare, and was probably of the nature of a fœtal occlusion; its diagnosis was only possible in the absence of suppuration of the middle ear, or in cases in which the suppuration had been of very short duration, as it necessarily took a considerable time for the suppurative cholesteatoma to form. His (Dr. Grant's) custom in the latter case was to perform a radical mastoid operation and to leave the matrix of the cholesteatoma *in situ*, if it seemed smooth and homogeneous. It was of the utmost importance, however, that the opening into the cavity should be as large as possible. In Mr. Stuart-Low's case, in which the cortical mastoid operation alone was done, he questioned whether it would not have been better to have done the radical mastoid operation, seeing that there was a history of long-standing ear disease. Possibly the cholesteatoma cavity had now got completely shut off from all sources of irritation, and might remain quiescent, as at present, but it would be important and interesting to watch the subsequent result of this very important experimental mode of treatment.

In reply, Mr. Stuart-Low said that he would bring these cases before the Society again in six months' time, so that the permanent good result of leaving the cholesteatomatous lining might be tested and inspected. The hearing power was retained to a much greater degree than was usual after a radical mastoid operation.

The President delivered his "Presidential Address," which appeared in our last issue.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held Friday, Nov. 17th, 1905.

Mr. Clement Lucas in the Chair.

Mr. Jaffrey showed a case of "Spina bifida" situated in the lumbo-sacral region, having also well-marked post-anal dimples. With the exception of some weakness of the legs there is no definite paralysis.

Mr. G. R. Wilson showed a female child with complete Hare-lip on the left side and partial on the right, with a cleft palate affecting the left side.

Mr. P. Lockhart Mummery showed a case of "Volkmann's Contracture" in a boy, æt. 12. Three years ago he injured his wrist and was treated by the application of splints; this was followed by ulceration of the forearm on the anterior and posterior aspects of the limb, and flexion of the fingers and wrist with wasting of the muscles. Mr. Mummery is of opinion that the best treatment for severe cases is resection of portions of the radius and ulna.

Mr. George Pernet showed two cases of "Tinea Tonsurans," one in a girl, æt. 9, and the other in a boy, æt. 11, who had been treated by one application of X-rays for twenty minutes. In the case of the girl she was quite cured and the hair was growing again, and in the boy, though the disease was cured, the hair had not yet grown. Mr. Pernet pointed out the great amount of time saved by this treatment.

Mr. Sydney Stephenson showed a case of "Obstruction of the Central Artery of the Retina" in a girl, æt. 15. On October 26th patient noticed what she describes as a "dazzling" in her left eye, and found that she could see parts of objects only. Ophthalmoscopic examination showed that the optic disc was indistinct, and the central part of the retina very pale, except as regards a small area contiguous to the lower outer side of the disc. The sight of the eye was reduced to the appreciation of shadows only. The obstruction is almost certainly due either to embolism or thrombosis of the central artery.

Dr. Farquhar Buzzard showed a case of "Atrophic Paralysis of the Right Arm," probably anterior poliomyelitis.

Dr. Poynton showed a case of remarkable results of "Anterior Poliomyelitis," with widely-distributed loss of power affecting the arm and trunk muscles.

Dr. George Carpenter showed a case of "Infantile Paralysis." A boy, æt. 4 months; been under the care of Dr. Cardy Bluck, of Southend. Attacked when 2½ months old, fever, anorexia and paralysis. Left leg reaction of degeneration. Right leg, loss of reaction to Faradism, but no polar change. The abdominal muscles did not react to Faradism.

Dr. F. Parkes Weber showed a case of "Peculiar Pigmentation of the Skin" in a girl, æt. 15, probably an incomplete form of Recklinghausen's disease. The earliest pigmentation was noticed at the back of the neck when the child was about eighteen months old. The patient presented only one small flaccid molluscous tumour.

Mr. Macintosh read a paper on "Some Points in the Diet of Children" during the second year.

Mr. Jaffrey read a short paper on a case of "Multiple Renal Calculi." The child had suffered for two years from frequent attacks of pain in the left lumbar region. At the operation Mr. Jaffrey removed eleven calculi about the size of a pea. The composition of the calculi was calcium oxalate with a small quantity of calcium phosphate.

Mr. R. Clement Lucas related a case of "Removal of a Calculus Impacted in the Ureter causing Hydronephrosis." This case which occurred in a boy, æt. 11, who had had loin pain and attacks of colic for eight years, that is, since he was three years of age. Mr. Lucas opened the hydronephrosis at the pelvis of the kidney and failed to find a stone, but, finding the orifice of the ureter dilated, extended his incision downwards and forwards to Poupart's ligament, and, displacing the contents of the iliac fossa forwards, found an elliptical stone impacted in the ureter about two inches below the kidney. The stone was removed through a longitudinal incision, which was closed with fine silk. The pelvis of the kidney was closed with chromic gut.

Dr. Cautley showed a specimen "Saccular Dilatation of Small Intestine," and one of "Diaphragmatic Hernia."

Dr. George Carpenter showed a case of "Hydrocephalus" in a boy, æt. 8. The patient is under the care of Dr. Cardy Bluck, of Southend. The head began to enlarge when three years old, and is said to have enlarged one inch during the last three weeks. He has commencing optic atrophy, with *tache cerebrale* well marked. Dr. Carpenter also showed a case of "Cirrhosis of the Lung and Bronchiectasis," and two case of "Pseudo-Hypertrophic Paralysis."

LIVERPOOL MEDICAL INSTITUTE.

Meeting held November 23rd, 1905.

Dr. R. J. Logan, Vice-President, in the Chair.

Dr. Leslie Roberts showed a man, æt. 42, suffering from "Anæsthetic Leprosy." The symptoms commenced about eleven months ago, a dusky red spot appearing at the tip of the right great toe. The toe is now swollen to twice the normal size and the redness extends to the dorsum of the foot. On the right forearm near the wrist there is another patch similar in colour. The skin is anæsthetic over these regions.

Dr. Grossmann showed a case of "Unilateral Ophthalmoplegia." The patient, a man, æt. 34, had suffered severe pain in the left side of the head for the last three months; otherwise he was in good health. Two months later the headache disappeared, diplopia was observed and the left eye-lid drooped. There is now complete ptosis and paralysis of all the eye muscles with the exception of that supplied by the fourth nerve, the eye-ball rolling on an antero-posterior axis when an attempt is made to look outwards and downwards. The pupil neither reacts to light nor to accommodation. The lesion was thought to be situated at a point where the third and sixth nerve perforate the meninges, and to be of a syphilitic nature.

Dr. T. R. Bradshaw fully agreed with the localisation arrived at by Dr. Grossmann, and felt confident that the lesion was syphilitic in origin, Quite lately he had seen a similar case of ocular paralysis undoubtedly syphilitic in origin. In this case, however, there was also paralysis of the hypoglossal nerve of the opposite side.

Mr. K. W. Monsarrat related a case of appendicitis complicated by subphrenic abscess and empyema. The patient was admitted to hospital five weeks after the commencement of an attack of appendicitis, which had been treated by medical measures. At the time of admission the signs of thoracic disease overshadowed all others, and the previous diagnosis of appendicitis was not then known. A small subphrenic abscess, and a large right-sided empyema were opened under local anæsthesia. Four days later an abscess, the presence of which was not at first clear, was opened in the right loin. This lumbar abscess lay in front of the right kidney below the liver, and extended downwards to the outer side of the colon as far as the pericæcal region. The patient was discharged well in seven weeks.

Dr. W. Carter as the result of many careful observations upon himself, stated that after swallowing 5 grains of potassium iodide dissolved in half a fluid ounce of water, the drug was recognisable in the urine in from 12 to 24 minutes, and continued to be found for from 35 to 40 hours. It appeared as early in the saliva and was observed in it from four to five hours longer. It was never found in the fæces. In these small doses (5 grains in 36 hours) potassium iodide gave relief from the pains of a crippling neuritis that had lasted for two months.

Dr. David Smart read a paper on

THE MODERN TREATMENT OF SYPHILIS.

He much regretted the general apathy in England on the subject of venereal disease, as instanced by the absence of Lock hospitals in large centres and in large naval and military stations. He referred to the great importance of general hygienic treatment, namely, rest to the body and nervous system; rigid regulations as regards tobacco and alcohol, laying especial stress on the antisepsis of the mouth and teeth. After discussing the value of mercury in the several stages he mentioned the three main means of administering it, by the mouth, by means of intramuscular injection and by inunction, expressing a decided preference for the latter mode of treatment both in private and in hospital practice. An interesting description of Aix-la-Chapelle and its inunction "Kur" was given, the paper concluding with an eloquent appeal for the more general adoption of this method in England.

Dr. Stopford Taylor said that during the last eighteen months he had regularly practised the intramuscular method of administering mercury, and the way in which patients had improved had been a revelation to him. He should be very sorry to return to the oral method of medication, and considered the routine treatment by inunction to be impossible in this country.

Dr. A. Bernard said when all the symptoms pointed to the syphilitic character of the primary lesion, it was his invariable practice to administer mercury without waiting for the onset of secondary symptoms. He greatly preferred to employ inunction or intramuscular injections rather than give the drug by the mouth.

Dr. F. H. Barendt said that in private as well as in out-patient practice he used the oral method, He found it on the whole the most satisfactory one, and it did not interfere with the patient's occupation and personal comfort, or betray his secret. When the nature and seriousness of the affection were placed clearly before the patient, no difficulty was experienced in keeping him under observation for three years.

Dr. Leslie Roberts spoke in favour of the oral method; in the later lesions of syphilis he had used inunction with marked benefit; he considered there was some appreciable danger in intra-muscular injections.

Dr. W. Alexander, Dr. W. B. Warrington, Mr. E. M. Stockdale, Dr. T. R. Bradshaw, Mr. F. C. Larkin, Mr. F. T. Paul, Dr. R. W. MacKenna and Dr. A. G. Gullan also took part in the discussion.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, November 26th, 1905.

Danger of Scopoleine.

At the meeting of the Société de Thérapeutique, M. Bardel called attention to a case of Prof. Monod, which terminated almost fatally under chloroform preceded by an injection of 1 milligramme of scopoleine and 1 centigramme of morphia, and said that though he knew that surgeons appreciated greatly this method, which seemed to guarantee accidents from chloroform, yet he considered that the dose was too large; that scopoleine was somewhat similar to atropine, and consequently the initial dose should not exceed one-tenth or one-fifth of a milligramme.

Dr. Landau, of Germany, reported recently 113 deaths due to these injections but in which the dose injected varied from 2 to 9 milligrammes.

M. Chevalier said he agreed with M. Bardel as to the prudence necessary in handling scopoleine. He could cite two fatal cases known to him that took place in the west of France. Considered as a commercial product, scopoleine was not always of uniform quality; its toxicity and activity varied frequently, consequently it should be used with prudence and the more especially when the patient's liver is affected.

M. Yvon expressed the opinion that the maximum dose of alkaloids in general was very difficult to fix in prescribing. The new Pharmacopœia in preparation abstains from giving it. In the old Pharmacopœia the granules of the alkaloids were at the dose of 1 milligramme, but in the new they will be fixed at one-tenth of a milligramme. Consequently the practitioner can handle them with much more assurance.

Treatment of Meningitis.

The medical world is always ready to accept any treatment that has proved of some benefit in cases of meningitis, the most dreaded and fatal disease of first childhood. A practitioner of the west of France publishes several cases of this affection treated successfully by the creation of abscesses (*abces de fixation*). Little encouraged by the results of the usual treatment of meningitis (purgatives, calomel, iodides, blister, ice, &c.) Dr. Laffond decided on trying the effect of artificial abscess. One of the cases concerned a child, æt. 3, suffering from vomiting, constipation, agitation, and fever; the pupils were unequal, while a considerable amount of stiffness was observed in the neck and the child gave out from time to time those piercing cries so characteristic of that malady. The case was evidently one of infectious meningitis, due to the pseudo-bacilli of Friedlander. The usual treatment having failed and the condition of the child being critical, Dr. Laffond injected twenty drops of essence of turpentine into both hips. Twenty-four hours afterwards the regions became inflamed and swollen, while the morbid symptoms improved. Twelve days afterwards all the phenomena of infection of the membranes had disappeared. The abscesses were incised a month subsequently, and the child finally recovered, but the convalescence was prolonged three months.

A second case was a little girl, æt. 5, presenting all the symptoms of acute meningitis. The patient fell into coma and the case was desperate. Forty drops of turpentine were injected into the buttock, and five days subsequently the patient recovered consciousness. Twenty-eight days after the injection the abscess was opened, but in this case, as in all the cases, convalescence was long and difficult.

A third case was that of tuberculous meningitis in a child of thirty months who finally got well. A fourth case, a girl, æt. 8, however, terminated fatally; although the injection of turpentine was given as in the other cases, no abscess was produced and the patient succumbed on the twentieth day of the malady.

Medical Treatment of Appendicitis.

The medical treatment of appendicitis, as recommended by Dr. Pauchet, is as follows:—Absolute rest. The patient must lie on the back with head but slightly raised, for one or two weeks. During five, ten or fifteen days, according to the intensity of the case, the patient will be given *nothing* by the mouth, neither milk, water nor medicine. This absolute diet is sometimes so difficult to obtain that the attendant will be obliged to allow a little water, but only a teaspoonful every quarter of an hour. No purgatives. A large number of patients die from perforation, because, believing it to be a case of indigestion, calomel or some purgative mineral water is ordered.

As regards opium, which has been so generally prescribed for ten years, it should not be given, as it paralyses the intestine and constitutes a slow poisoning of the patient. If great suffering is complained of, an injection of morphia may be given, or an enema of 15 grains of antipyrine. Purgative enema should also be proscribed as dangerous, as an excess of pressure might determine the rupture of adherences or the bursting of an abscess.

Nutritive enemas. Since the patient is totally deprived of absorption by the mouth, water and nutritive elements must be introduced into the system by the rectum and the skin.

The enema which M. Pauchet employs is the following:—

Sugar, 1 teaspoonful or 1 lump;
Salt, 15 grains;
Water, 4 ozs.

To be renewed five or six times in the twenty-four hours.

Besides these enemas he injects into the muscles of the thigh the following solution:—

Sugar, 1 oz.;
Salt, 1 drachm;
Water, 1 quart.

From 10 to 20 ounces are injected in the twenty-four hours.

Local treatment: the ice-bag, if ice is obtainable, otherwise warm applications may be used.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, November 28th, 1905.

At the Medizinische Gesellschaft, Hr. Hirschfeld spoke on

Pancreatic Disease during Diabetes.

In fourteen cases of diabetes he had observed symptoms which he took to be due to disease of the pancreas. They consisted of colics that lay more towards the left than would have been the case with gall-stones, but they were very difficult to distinguish from angina pectoris. As a rule also there was increase of glycosuria and acetonuria, such as was usually observed in cases of boils, gangrene, febrile diseases or psychical excitement in the course of the disease. Not infrequently there was œdema that went hand in hand with diminishing excretion of water. With all this, one saw circulatory disturbances which might be due to disease of the liver. The essential cause of this was unknown. The course of disease of the pancreas was mostly favourable, its duration was as a rule one to four months, but permanent damage might result from it. Twice the speaker saw transition into coma; no autopsy was made. The danger of recurrence was not to be underestimated, for it might have an unfortunate termination.

Hr. Rosner spoke on

Prostatic Hypertrophy and Diabetes.

He called to mind those cases in which polynuria remained for a lengthened period after disappearance of the sugar from the urine—a symptom not infrequently observed in old men. If hypertrophy of the prostate were present one should accustom oneself, in spite of low specific gravity, to test for sugar. He had found sugar five times in thirty cases of prostatic enlargement.

This frequent coincidence was not accidental, but it came about by way of arteriosclerosis which disposed to diabetes. If sugar were found in the urine of a man with prostatic enlargement, there was double ground for thinking of arteriosclerosis.

The simultaneous presence of prostatic enlargement and diabetes made the regulation of the diet difficult, as prostatics with retention of urine generally had a dislike to flesh meat, which was the staple food of diabetics. The proof of sugar was also of importance as regarded treatment. First the sugar increased the dangers of cystitis from the use of the catheter, and the prognosis in case of operative interference was rendered less favourable whether the treatment proposed was Bottini's electrical cauterisation or extirpation.

Veronal—a Warning.

The *Deut. Med. Zeit.*, No. 89, contains a reference to a paper by Dr. Kress in which a most unfortunate ending followed the abuse of veronal. The patient was a hysterical young woman of 23. Veronal was given, and after three doses of 8 grains each, its action appeared to be cumulative, and its administration was interrupted. It was given again later on, but the patient appeared to have contracted a strong liking for the effects produced, so much so that on her return home she procured the drug from an old prescription. It appeared that after the beginning of January of last year she took every evening first ½ gramme, then 1 gramme, and lastly 2 grammes.

The writer in conclusion calls to mind Jolly's advice—only to give veronal periodically, and often vary the medicine; further to begin with the smallest effective dose and get the medicine out of the system at the earliest opportunity. That it has caused acute dermatitis in many cases when its use has been prolonged beyond four or five consecutive nights is well known. It is evidently a drug to be employed with caution.

At the Society fur Innere Medizin, Hr. O. Rothmann spoke on

An Epidemic of Diphtheria.

Some time ago he attended a medical man, æt. 39, for diphtheritic angina. The deposit disappeared in four days, but convalescence was protracted into weeks. Three days later his four-year-old son took ill of angina lacunaris, but soon recovered, and two days later a three-year-old daughter was taken suddenly ill with a throat affection, but she was free from fever on the following day. Three days later two more children were taken ill, but were also free from fever on the following day, and a week later a daughter, æt. 8, was slightly feverish, the fever terminating as in the other cases. The speaker believed that all these cases were connected, and that in the cases of the children affected later the disease was to be looked upon as a diphtheria without local symptoms.

Hr. Flatau gave a short note on

Acidol.

A substitute for hydrochloric acid, a preparation made from the residue left in the manufacture of sugar. It was a white powder that had been brought into the market in the form of pastilles. It was readily soluble in water—half a gramme was easily dissolved in half a wineglass of water—and contained 25 per cent. of hydrochloric acid. Acidol had a marked digestive action, and had no injurious by-effects. A combination with pepsin kept unchanged for many months. The price was 2s. 6d. for 50 pastilles,

Fæcal Tumour mistaken for a Fibroma.

The *Munch. Med. Woch.*, 16–05, contains an account of a case by Dr. Wiener, in which a fæcal tumour was mistaken for a fibroid. The patient was a woman, æt. 39, who had borne eight children, the last fourteen months previously. The patient had suffered from constipation for years, for which she had constantly to take medicines, but with these there was rarely a day in which the bowels were not open. She complained of sacral pain and violent pain on defæcation. On internal examination a firm tumour was felt impacted between the uterus and rectum. The tumour was roundish and had a smooth surface. The rectum was free from fæces. A diagnosis of fibroma of the right ovary was made.

The patient was prepared for operation by a preliminary dose of compound liquorice powder and several enemata, which were followed by copious evacuations.

On examining the patient again before operating, the writer was astonished at finding the tumour lower down and softer, so that an impression could be made on it with the fingers. Both ovaries could now be plainly felt, near the uterus. The diagnosis was now changed into one of fæcal accumulation, and the patient was given oil enemata freely, and high up and repeated pv. liq. comp. Stools were now more frequent and the swelling became less, and in a few days what remained was only the size of an egg. After removal of the tumour the patient felt as if newborn, and absolutely free from all pain.

The tumour was so very movable whilst there that it must have lain in the sigmoid flexure.

Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, November 26th, 1905.

Surgical Instructions.

The Gesellschaft der Aerzte was invited by Eiselberg to meet in his class-room so that he might better demonstrate to the members his new method of teaching surgery which he has practised during the last year.

His five double-hour klinik treats of surgery in general in a systematic manner, commencing with the most important in general practice first—wounds, with illustrative cases. Acute inflammation follows, with hernia, peritonitis, &c. Twice a week he recommends appropriate operations at the end of the lecture. For major operations he invites eight of the students to meet him in the operating theatre between eight and ten in the morning, while five to six in the evening is devoted to minor operations by his assistant.

During the latter hour the student is taught how to give subcutaneous injections, transfusions, and the importance of sterilisation.

He recommends operations on the dead body during the winter months, which he divides into general and forensic surgery.

The modern devices, such as skioptics, episcopic and diascopic are practised with Zeiss' instruments. Projections on canvas, paper, &c., as well as finger impressions in agar and microscopic photos with the lantern were all necessities of the modern student in medicine.

Pubic Division—Hebetomia.

Franqué showed a patient, æt. 32, who had been confined for the ninth time, three weeks previously, after dividing the pubis according to Gigli's method. The first six children she bore were all dead, but the seventh and eight confinements seemed to pass off easily with a live child on both occasions. The ninth or last confinement seems to have been delayed four weeks, allowing the fœtus greater development, which appears to have been the principal cause of the unusual difficulty in delivery. The pelvis was somewhat flattened in shape, though not unusually low, in measurement being 24 and 26 with a diagonal measurement of 10½ cent. When the patient was received into hospital the membranes had been ruptured seventeen hours previously, and the pains were very feeble. Franqué applied the instruments with no effect on the movement. The temperature was 37° C. The catheter was applied to enter the bladder, but nothing but blood could be obtained. The pulsation of the child's heart was good ; meconium was discharging from the vagina, while the head lay in the first position, fixed tightly in the canal, and the soft parts jutting far down in a conical form. Turning was scarcely possible. Cæsarian section was contraindicated by the high temperature, which left no other resource but perforation and crushing of the child's cranium, or hebetomy, after Gigli. Before deciding on either of the operations, Franqué resolved to try Breuss' axial traction forceps, but after four efforts without the slightest effect, he unlocked the forceps and determined to perform hebetomy. Slightly to the left of the pubic tuberosity he made a transverse incision 5 cent. long ; through this he passed the finger behind the pubic bone ; closely under the same incision he made another near the vulva passing into the finger. Into this canal he passed a chain saw and divided the pubis. Having completed the incision, he again adjusted the forceps and delivered with a loud crashing noise from the tearing asunder of the ligaments and posterior cartilages. After the head was extracted the shoulder gave a good deal of trouble. When the wounds were examined it was found that the bones were fully two finger-breadths apart. The vagina was then washed out and strips of iodoform gauze inserted into the wounds, the whole retained in position with broad bands of adhesive plaster round the pelvis. Subsequently it was found that the uterus was pressed backwards and the bowel thereby constricted, causing troublesome metorism, vomiting and fainting. On relieving the adhesive plaster all the untoward symptoms disappeared, the temperature became normal and the patient speedily recovered, the pelvis uniting within twenty days without any callus deposit. The child weighed 4751 grammes, and is now doing well, although the left arm is contracted and paresis present. There is still a hæmorrhagic tumour on the head from the effects of the forceps. Franqué considered hebetomy superior to symphysotomy as described by Morisani, which prolongs the convalescence and is apt to produce fistula with urinary incontinence and imperfect union of the symphthysis, debilitating the patient for future work. Gigli's method is indicated when the conjugate does not exceed 6¾ cent., but the above was an exception. He has performed this operation forty-two times with only two deaths from septic poisoning, where labour had been allowed to linger too long.

Hungary.

[FROM OUR OWN CORRESPONDENT.]

Budapest, November 26th, 1905.

At the recent meeting of the Budapest Royal Society of Physicians, Dr. Menyhert described a method by which the postero-superior abscess of the liver may be reached and surgically treated without risk of contamination of the pleural or peritoneal cavities. The operation devised by him is to be performed thus :—The patient being placed upon the left side, an incision 12 mm. long is made along the ninth rib, starting from its junction with the cartilage. Two incisions, having their origin in the seventh intercostal space, are made to meet the two extremities of the first. The flap thus made is dissected and laid back, the eight and ninth ribs laid bare, denuded of their periosteum and resected (the former to the extent of 8 cm., the latter 10 cm.), without injury to the pleura. With the finger the parietal layer of the pleura is then stripped from the ribs, below the incision as far as its reflection upon the diaphragm. Then, raising, as far as possible, the cul-de-sac of the pleura, an incision is made in the diaphragm which gives egress to the pus. Two large drains are then inserted in the wound, these being removed upon the ninth day, and the wound is completely closed within about a month. This method has been first introduced by P. Mendes, who named the operation parapleural transdiaphragmatic.

Adrenalin in Cancer.

Dr. Polya discussed the Fiesinger method of treating cancers with adrenalin. Nominally, Fiesinger holds that adrenalin is capable of modifying the vascularisation of cancerous tumours. In cancer of the rectum, painting twice daily with from 30 to 100 drops of a 1 in 1,000 solution of adrenalin in a tablespoonful of water decreases the accompanying rectitis, may check the discharge, and brings about a temporary diminution in the size of the cancerous growth. External ulcerated cancers become pale, decrease in volume, the hæmorrhage may be checked, and the progress of the affection is stayed for a time by the use of this remedy. Combined treatment with adrenalin, quinine and beer yeast is, in the author's opinion, distinctly serviceable in the prevention of recurrence after ablation of cancerous tumours. He reported the case of a woman operated upon in 1902 for cancer of the uterus, in whom, the operation being incomplete, a recurrence was expected. During 1902 and 1903 the patient was given quinine hydrochlorate 0.25 in cachet before breakfast and dinner for five days, the two remedies being alternated thus for a month, at the end of which time treatment was suspended for five days and resumed in same order. In 1903 adrenalin was added to the treatment, 5 to 10 drops of the 1 in 1,000 solution being given on rising and retiring, on the days on which the beer yeast was given. At the present writing the patient continues to enjoy excellent health. In another case, operated upon three times for cancer of the breast, which recurred very shortly after each operation, this treatment was given, with the result that seven months have elapsed without a reappearance of the cancerous growth.

Beckmann publishes two cases of

Callus Formation in the Fractures of Osteomalacia,

from which some interesting results are drawn. Rontgen rays were employed in these two cases, and although the skiagraphs were taken several months after the injury, no signs of any callus formation were seen. In one case there was a very faint shadow around a fracture of the bones of the forearm, around which some degree of union seemed to have taken place, but the very slight deposit of lime salts permitted the rays to pass through without interference. In the other case the fragments were not in apposition, and the picture taken five months after the injury showed absolutely no evidence of repair. The author thinks that the reason that in one case there seemed to be formation of a functional callus, but without the presence of lime salts, while in the other there were absolutely no traces of a callus, is due to the fact that osteomalacia in the former case had not advanced as far as in the latter. For it is a well-known fact that the further along the disease advanced the less likely is repair apt to take place. These observations also show that the X-rays afford a very effective means of gauging the stage to which the process has advanced, for, in the first case, the bone presented a spotted or marbled appearance, while in the other nothing could be detected of any bone structure. This may be of great value in doubtful instances.

Operating Theatres.

GREAT NORTHERN HOSPITAL.

Ventral Hernia with Appendicitis.—Mr. **Peyton Beale** operated on a man, æt. about 30, who had been admitted with a large ventral hernia at the site of an old scar in the right inguinal region ; the history of the patient was as follows :—Four or five years ago he had an appendix abscess which was opened and drained. He said that the appendix had not been removed on that occasion. He had suffered from recurrent abscesses about the same region on four or five separate occasions since that time, and he now complained of a very large ventral hernia which caused him considerable pain and was not amenable to treatment with any belt or truss, and which was in danger of becoming strangulated, The patient's general condition was not very good, though there was no evidence to show that there was any suppuration now going on, but at one hospital at least he had been refused operation without any reason being stated ; however, the case now appeared somewhat urgent because of the risk of strangulation. An incision about five inches long was made parallel to the old scar and about an inch below it, passing through skin and fascia only ; this exposed the cæcum and some small intestine, which were firmly adherent to the under surface of the skin cicatrix ; these were carefully separated and a finger was passed freely round the scar and subsequently all round beneath the aponeurotic and muscular layers, thereby disclosing an aperture in the latter about five inches long and three inches wide. The peritoneum was not encountered at all, having, in all probability, retracted for some distance beneath the muscular layers. On introducing the hand into the abdomen a hard firm tumour about the size of an orange was felt behind the cæcum, and on being manipulated, it ruptured and discharged about four ounces of very foul pus ; this was rapidly irrigated out and the cavity from which it came temporarily stuffed. On further examination a very thickened appendix was found lying behind the abscess and firmly adherent to the fascia over the iliacus. The adhesions were broken down, the appendix brought out of the wound, its base ligatured, and the appendix, the walls of which were about half an inch in thickness, and which contained two or three perforating ulcers, was removed. The wound was then thoroughly irrigated and a fresh incision through all the layers of the abdomen was made about three inches behind the position of the original cicatrix ; a large gauze drain was inserted into the pelvis through this wound in order to drain the site of the abscess, and the situation of the appendix stump. The edges of the muscular layers of the abdomen which formed the hernial aperture were next freshened and brought into apposition with strong catgut sutures. The original cicatrix in the skin was then completely excised and the edges sutured together, in the hope that the hernial aperture might be thus permanently closed, the depths of the wound being drained by the new posterior incision. Mr. Beale said that the case was an interesting one, as it showed how in certain instances, if the appendix were left, recurrent abscesses formed repeatedly; in some instances, as in the present one, these abscesses were purely local, but in many cases they were likely to be found in other situations, having tracked up from the appendix to the hepatic flexure of the colon, or, from following the transverse colon to its splenic flexure, spreading upwards and forming a subphrenic abscess, or burrowing deeply into the pelvis, perhaps behind the bladder, and finally opening into the rectum or vagina, or into both. In this particular case he pointed out there was no evidence to show that any suppuration was still going on. Of course, he remarked, the operation was a serious one in that it was impossible to prevent infection of the general peritoneal cavity when the foul pus escaped from so deep a wound, but he thought that it seemed preferable to run this risk rather than to leave the case alone when a very large strangulated hernia would be almost certain to give trouble sooner or later. He pointed out that in these cases it was necessary to make the preliminary incision with the greatest care, because some intestine was almost always found adherent to the skin cicatrix, and it was very easy to wound it. It was practically impossible, he considered, to find and isolate the edges of the peritoneum, and even if they could be found, it was nearly always impossible to bring them together. There was, he said, of course a certain element of risk of subsequent intestinal obstruction by the formation of adhesions between some part of the bowel and the under surface of the sutured muscular layers.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 29, 1905.

MEDICAL WITNESSES.

THE essential difference that exists between law and medicine is never so glaringly apparent as when they meet in practice. It is almost impossible for a matter-of-fact barrister fully to enter into the feelings of a scientific medical man, and it is nearly as difficult for a medical man to adopt the narrow standpoint of the barrister. The matter may be briefly summed up by saying that medicine is still an inexact science and an imperfect art, and as such it is not adapted to the hard-and-fast legal system of the country. The barrister—and the judge too—wants cut-and-dried facts to put to the jury, while medicine is in practice often unable to supply anything more than a general opinion. In human affairs it is a matter of common experience that when a general opinion only can be given, then will be found almost as many opinions as men. We have lately had a complaint from the Secretary for War to the effect that every single soldier he consults has distinct individual views on military subjects, and that he himself is reduced to something like impotence from following first this counsel and then the other. So far as matters of fact are concerned medical men can generally arrive at some sort of agreement, but when questions of deduction from these facts arise each man will give an opinion as his knowledge and experience guide him. Without there being any suspicion of want of candour or want of capacity, it is thus possible for divergencies of great extent to be presented by this and that man's evidence as to the same facts, and the hard-headed British juror and the cut-and-dried lawyer are apt to come to the conclusion that medical evidence that varies within such wide limits is not worth much. If lawyers would but regard their own experience it would be perfectly plain to them that individual opinion is as much the breath of their own nostrils as it is that of the doctors; for if cases could be brought accurately within the words of any statute, and judgments were given automatically, a hundred lawyers could do all the work of the country. As it is, the same question submitted for half-a-dozen K.C.'s opinions will not infrequently produce six different results, and even in matters of a judge's interpretation of the law one knows that a large proportion of judgments are overruled or reversed. It may be, and among the more intelligent lawyers probably is, the fact that these considerations are not altogether unappreciated; but it is even more certain that when cases come into Court the advocate on each side will try to break down and discount the medical evidence brought forward by his opponent, by dwelling on the points at which the witnesses are in conflict and by disregarding those in which they are in agreement. Now although this may be good tactics, it is very bad for medical credit and medical dignity. In the law courts the lawyers are in office, so to speak, and as they enjoy all the talking and always have the last word, it is not surprising that medicine seldom "scores" and is generally in the humiliating position of being either abused or laughed at. Yet in practically all cases in which medical evidence is needed it is on that evidence that the case rests, and by it that justice is administered. Medicine, therefore, is entitled at least to a position of dignity. With a view to reducing the reproaches that have been cast at it, a proposal has several times been put forward that medical witnesses engaged in legal cases should meet in consultation, before the trial of any action, in order to settle points of common agreement and define accurately points of divergence. An instructive debate on the subject recently took place at the Medico-Legal Society. Mr. Justice Walton presided, and several medical and legal members spoke. On the part of the lawyers it was noticeable that a sympathetic attitude was observed, and that when the facts were placed before them they entered into the difficulties surrounding the medical position. In the course of the debate a long letter from Professor Clifford Allbutt was read, in which the writer stated that when he was in practice in Leeds he was frequently consulted by large railways with regard to compensation claims. In the trial of action arising out of those claims he was so much struck with the hollowness of the alleged medical disagreements, and the discredit reflected on medicine by the exaggeration of those disagreements in court, that he initiated a system of consultation between the medical witnesses and the solicitors for each side to remove the reproach. The system worked admirably and was quite as much appreciated by the lawyers as by the doctors. Two further proposals were made in the course of the debate, one that a medical arbitrator should be appointed who should be competent to inquire into the medical aspects of a case and cross-examine the witnesses before the trial; the other that a medical assessor should be available to help the court. It has been shown in practice that the admirable system of medical referees instituted by the Home Office in connection with the Workmen's Compensation Act is not used by the County Court judges, and Mr. Justice Walton pointed out that under English methods of procedure a medical assessor could not possibly be engaged in a trial conducted before a jury, although in the Admiralty Court where cases were tried solely by a judge the presence of a nautical assessor was of high value towards securing a just decision on the facts. It seems, then, that the profession have little to hope for in the way of assistance from the Courts towards securing unanimity or substantial agreement on vital points, and thereby consulting not only the interests of justice but its own dignity. Consultations, however, it can insist upon, or at least press for, and if the medical witnesses on both sides desire a consultation the solicitors and counsel would be practically forced to consent. The only objection is that of expense to the parties, but in most cases this would be infinitesimal compared with the sums at stake. At any rate, in all cases where it is feasible there is no doubt that such consultations should be sought, and medical witnesses will deserve well of their profession when they ask for them. No one who is sensitive as to the honour of his profession cares to see his colleagues or himself held up to opprobrium or ridicule before a court of laymen.

THE CONJUGAL TRANSMISSION OF TUBERCULOSIS.

Pulmonary tuberculosis is now universally recognised to be a transmissible disease, although opinions differ within wide limits as to the facility with which such transmission takes place. The question is specially interesting in regard to the risks run by married people when one or other of them succumbs to the disease. General impressions are untrustworthy, and it is only by the statistical method that we can hope to arrive at an approximately correct idea of the actual incidence. Dr. Kool, of Kollum, has taken the trouble to investigate the life history of a certain number of widows and widowers whose partners had died of tubercule, and his results are worthy of note. Having ascertained from the death registers the names of married persons who had died of pulmonary tuberculosis, he proceeded to extract from the registers the cause of death of the survivors. Control statistics were provided by making similar researches in regard to the deaths of married persons from other causes. The first group comprised 175 individuals with 29 deaths, 8 of them being due to tuberculosis; in the second group 195 persons with 31 deaths, 3 only from tuberculosis. The survivors in both categories were followed up for periods varying from five to seventeen years and the results tabulated according to age in order to admit of fair comparison. He found that of 25 widows or widowers whose partners had died of tuberculosis, and who had themselves died between 20 and 30 years of age, none of them succumbed to that disease; of 46 who died between 30 and 40 years of age, 7 died of consumption; of 40 who died between 40 and 50 all died of some other disease than tuberculosis, and of 64 who died after 50 years of age only one fell a victim to tuberculosis. With regard to the survivors of non-tuberculous partners the figures corresponding were 0; 0.8; 0.9; 0.8; and 0. It follows that between the ages of 30 and 40 the proportion of deaths from tubercle was nine times greater than in the second category; in other words, the risk of contracting tuberculosis is nine times greater on the part of the husbands and wives of tuberculous persons than in respect of the general married population. The fact that this excessive tuberculous mortality is not due to feebleness of constitution is shown by the fact that their mortality from other causes was not above the normal. The point is also illustrated in another way; for while the mortality from tuberculosis was only 1.1 in 46 for all widows and widowers indiscriminately, it was 7 in 46 for those whose partners had died of tuberculosis. It is certainly a significant fact that at a period of life which may be taken to correspond to recent widowhood the tuberculous mortality is eight or nine times above the normal. This, indeed, is only what one would have anticipated, but these statistical results establish the reality of the risk incurred by married persons afflicted with a tuberculous conjoint, and the knowledge may perhaps induce more prudence on the part of young people in concluding marriage with weak-chested partners.

DID HARVEY DISCOVER THE CIRCULATION?

The *Westminster Review* for July and August of this year contain two important papers by Dr. John Knott, of Dublin. The exciting cause for these papers lay in certain statements made by Dr. G. G. Greenwood, in the course of an article on Shakespeare, which criticised some of Dr. Knott's previous assertions and quotations. In replying to these criticisms Dr. Knott took the opportunity in the papers under notice, to pass from the well-known speech of Menericus Agrippa containing the parable of the belly and its members to a general argument about the circulation of the blood as known to the ancients, and thence by an historical transition to Harvey and his discovery. As is the case in everything that flows from the facile pen of Dr. Knott, these papers teem with research and erudition, and it is just on account of these qualities that the conclusion reached by the main thesis, namely, that Harvey did not discover the circulation of the blood, seems to us to merit serious attention. We have seen anti-vivisection pamphlets in which the same statement is made, but like most of the effusions of militant antivivisectionism, these pamphlets cannot be regarded as serious contributions to criticism, and they have indeed been dealt with in other quarters. In the case of Dr. Knott, however, such a conclusion, supported as it is by numerous quotations from ancient medical literature, and reached by an ingenious chain of argument, should not be allowed to pass unchallenged, that is, unless we are prepared to admit it as proven. This we are far from doing, and we need not go outside the bounds of Dr. Knott's papers to show that in every practical, effectual. and etymological sense Harvey was actually the "discoverer" of the circulation of the blood. It is not necessary to go back to Hippocrates, as is done by Dr. Knott, in the search for priority in the discovery, for though it is undoubted that Hippocrates knew not only that the blood moved, but that it flowed in the arteries and veins, it is clearly shown by a passage cited by Dr. Knott that Hippocrates was not above owning that he had no clear notion of the systematic disposition of the veins. Aristotle, too, is quoted, and it is plain that that great philosopher not only distinguished arteries and veins, but that he knew that the heart drove the blood into one or other of them. So, too, through the writings of all the ancient natural scientists it is clear that no lucid, accurate and comprehensive idea of the circulation of the blood was known to them, though most of these writers had some definite knowledge about the vascular system, and some theories as to the functions of its component parts. It is not till after the revival of learning that we come to any close speculations on the subject, and even from the writings of so learned a man as Rabelais, a long extract from which is quoted, it is plain that, though he recognised the heart as the principal vascular organ and the arteries and veins as distinct channels, this author had most erroneous ideas of the movements of the blood. Dr. Knott draws attention to a remarkable passage in the *De Christianismi Restitutione* of Miguel Servetus, in which the pulmonary circulation and the aeration of the blood in the lungs are categorically set forth and the flow of the blood into the arteries mentioned. This treatise of Servetus was unfortunately destroyed by Calvin's instrumentality, and the author himself burned, so that it is doubtful how far, if at all, subsequent anatomists were indebted to him. Cesalpino, his contemporary, however, was aware of these facts, and explained that there was a perpetual motion of the blood from the vena cava through the right ventricle to the lungs, and thence through the left ventricle to the aorta. On this ground Dr. Knott hails him as discoverer, or at least first publisher, of the circulation of the blood. No one has ever denied, so far as we know, that Cesalpino had a far clearer idea of the circulation than his predecessors, but it is probable that other contemporary scientists, as indeed is shown by the independent testimony of Servetus, had similar notions. It is equally clear that neither they nor their immediate successors, such as Sarpi and Fabricius, at Aquapendente, had a comprehensive grasp of the whole plan, sequence and continuity of the circulation. To us it appears that Dr. Knott settles this point by relating how Fabricius refers to the "flux and reflux" of the blood. The value of the veins were by this time part of the stock of the knowledge common to all Italian anatomists; their function and relation to the flow of the blood only remained to complete the demonstration. This task fell to Harvey's lot. The establishment of the discovery to his own satisfaction, and even more so to that of his contemporaries, was not a matter of the shrewd speculation of the moment. It was the result of study of the knowledge of the time, of experiment, comparison, of anxious thought, of demonstration, of publication, and of the conversion of other minds to his views. Harvey was no mere picker of other men's brains, but an earnest, working scientist, and it is his glory to have gathered up all the threads of imperfect knowledge and to have woven them into one continuous, consistent whole. It was by this constructive, architectonic labour that Harvey became a discoverer; a revealer to others. No great discovery has leapt in the world fully fledged, like Athene from the brain of Zeus; the process of Nature is an evolutionary one. Each labourer is entitled to his full credit, but the crowning glory rests, and rightly rests, with the master who coördinates the inchoate efforts of his predecessors. Organic evolution was a subject of burning speculation at least from the time of Erasmus Darwin, but the honour of piecing together the observations of others and giving them the magic touch which made them all fall into line was reserved for the genius of his grandson Contemporary evidence, both in England and on the Continent, is abundantly clear on the fact of Harvey's being "regarded as the discoverer of the circulation," and such evidence, as in the Shakespeare-Bacon controversy, is worth more than speculations formed two or three centuries later, unless "new facts" of vital importance are brought into the field. As it is, the position of Harvey is secure.

Notes on Current Topics.

Medical Inspection of Schools.

Two changes of great importance have recently taken place in the elementary schools of this country, both the result of long-continued agitation in medical and lay journals. We refer to the medical inspection of children and to the feeding of the hungry. Neither of these is yet fully developed, but a departmental Committee of the Board of Education, appointed last March by Lord Londonderry, has just reported on the present and future of these two new factors in school life. Of medical inspections in its result they speak in high terms, and it is something indeed gained, as the result of years of pressure, that laymen are now able to appreciate the value of this measure. Medical inspection, of course, does not entail treatment; all it does is to point out defects and recommend parents to have attention paid to them in the proper quarter. With regard to children's eyes, most praiseworthy work has been done in this direction, and hundreds of children who were recently being scolded and kept in for stupidity, are now, through the agency of spectacles, bright and happy members of their classes. Cleanliness has markedly improved, vermin have been tackled, and ringworm early diagnosed and put under control. Mentally defective children have been provided with special classes, surgical apparatus recommended in suitable cases, and minor physical defects remedied. Infectious diseases, especially diphtheria, are now far more easily controlled, and in some areas outbreaks have been cut short by timely diagnosis. All these benefits have been secured at a cost nowhere exceeding 1-10d. to the rates of urban districts. The arrangements for supplying "underfed" children with food are now fairly in working order, and where necessary the cost is being recovered from the parents. It is difficult to estimate what all this means in the prevention of suffering to the children and the increased efficiency of education.

Family Tremor.

THE disease sometimes called by the above title is one which has not received much attention, though isolated observers have from time to time through the past hundred years recorded instances of it. The tremor is usually rhythmical in slow time, perhaps five or six vibrations per second, though in some cases marked chaotic movements supervene. The hands are usually most affected, the eyes less so, and emotion or excitement increases the tremor. It is curious that the patient may often learn to carry on occupations requiring great delicacy of touch, while at the same time any unwonted movement calls forth the tremor. The disease is probably often overlooked, as the symptoms may be slight in degree, and not cause any inconvenience, or, on the other hand, it may be mistaken for senile tremor or the tremor of alcoholism. Schmatz has recently called attention to the condition, and has published records of a series of thirteen cases occurring in one family. The disease is transmitted by either parent, and is in some families associated with epilepsy. Indeed, some physicians have regarded the tremor as merely a symptom of widespread nervous degeneration, and have pointed to the emotionalism and nervous instability which sometimes accompany it as proof of this view.

Practical Teaching in Operative Surgery.

SOME months ago we referred to a new method of teaching operative surgery, introduced by Cushing. It consists in the substitution of surgical operative work on live animals for the old method of work on the cadaver. The plan has now been adopted at Johns Hopkins Medical College, where a well-equipped building of large size is devoted to work of the sort. At Columbia University, in response to a memorial of the students, praying for more complete surgical teaching, a similar move has been made. A comfortable hospital for animals has been provided, and the members of the class take in turn the duties of operator or assistant, of anæsthetist, of family physician, and of censor. The duty of the censor is to enforce aseptic thoroughness, and he has absolute control over all details of technique in the theatre and preparation room. The family physician is in clinical charge of the case, and is responsible for a complete clinical history. Up to the present the course is a voluntary one, but more than half the entire surgical class avail themselves of it, and the proportion is likely to increase in the future. There is no doubt that practice in operations on the live animal is at the least a useful supplement to instruction on the cadaver.

The Utility of Disease.

MANY thinkers from time to time, particularly since the adoption of the doctrine of natural selection as applied to man, have spoken of the value to the race of disease, and of the danger to the health of the race from the operation of humanitarian schemes. Disease, say they, is an enemy to the individual, but a friend to the race. The function of disease in the world's economy is to weed out the unfit, and thereby leave the human race sound and healthy. However well founded in the abstract this doctrine may be it is not one that can be used as a guide to conduct by the medical practitioner, whose duty is primarily to the individual and not to the social group. It is not, however, in any such sense that Sir Frederick Treves lauds disease in his recent address before the Philosophical Institution of Edinburgh. Using the term in the vulgar sense of the symptom-complex which is the result of any pathological process, he has little difficulty in showing that disease is in reality a protective process. It is not only, we fear, on the lay public that this idea has to be impressed. There are still many medical men who believe that cough or inflammation is an evil and is to be got rid of by any means in their power. Coughs are to be treated with sedatives, and inflammation with antiphlogistics. Nothing can be farther from a rational treatment. Symptoms are in most cases parts of the protective process of the organism, and not merely meaningless symbols of a pathological process. A rational treatment would therefore proceed along the lines suggested by the symptoms, and not in an opposite direction.

Hysterical Blindness.

THERE are few motor or sensory disturbances to which hysteria does not occasionally give rise. Among the less common of these is blindness of one or both eyes, without, as far as can be discovered, any organic cause or accompaniment. A number of cases of this sort have recently been collected by Dr. A. D. Williams, of St. Louis, (*a*) which show a marked similarity. The onset of the disease was in every case sudden, and in most unaccompanied by other hysterical symptoms, although the subjects were what is commonly called "neurotic." In most of the cases the blindness was of both eyes, though in two only one eye was affected; this is contrary to the general experience, since, according to Gowers, hysterical blindness is rarely bilateral. The most interesting point noted by Dr. Williams is the curability of the condition. Any severe shock, such as a sudden fright, was sufficient to bring about a complete and, what is more important, a permanent cure. In one case a fictitious alarm of fire caused the totally blind patient to traverse rapidly and in safety a room crowded with furniture, and to rush down a flight of steps into the open air; on recovery from her fright, she was surprised to find her sight quite restored. In another, the artificial shock of a strong application of the electric battery caused immediate recovery.

Scopolamine as an Anæsthetic.

DURING the past few months several reports have been published bearing on the use and value of scopolamine as an anæsthetic. It would appear that in this country it has as yet hardly got a fair trial. It is usual to administer the drug hypodermically in repeated doses of one sixty-fourth of a grain accompanied by one-sixth of a grain of sulphate of morphia, four hours, two hours, and one hour before the time fixed for operation. The result is a quiet, restful sleep giving two or three hours good anæsthesia. The patient wakes up as from a natural sleep, without nausea, thirst, or other discomfort. During the whole period he may be roused by shaking or loud talking, and it is advisable to plug the ears with cotton and to forbid talking in the operating room. During the skin incision the patient may move slightly, but it is rarely necessary to deepen the anæsthesia on this account. If necessary a very small dose of ether or chloroform is sufficient to give complete quietude. The principal disadvantage of scopolamine is that it does not give complete muscular relaxation, and therefore ought not to be given in operations where complete relaxation is required. It is not likely, therefore, to have a vogue for abdominal operations. Its advantages in suitable cases, however, are considerable, since it does away with all the pre-operative and post-operative annoyances associated with the use of the commoner anæsthetic agents.

American Medical Reviews.

SOME outspoken notes appear in our contemporary, *American Medicine*, about the way that some medical journals and their editors treat books written by rivals and published by rival firms. From these notes we gather that some of these American journals either do not review at all or review in an illiberal and captious spirit books sent to them by physicians who contribute articles to other journals, or by publishers whose business competes with that of the publishers of the journal to which the book is sent. For this reason, it is said, a physician who wishes to be well reviewed has to give hostages to fortune by sending his articles now to this paper and now to that, and his books to different publishing houses in turn. To English medical journalists it is almost incredible that such petty spite can animate the conductors of a responsible organ of opinion, and we hope sincerely that the facts mentioned are as exceptional as they are reprehensible. But we think that our contemporary is not fair to English journalism when it proceeds to suggest that the review given to an American-written book is founded principally on the spelling. No doubt in this country we prefer the old ways of orthography to the new, and *gynæcology*, *œdema*, and *tumour* are more pleasant to our eyes than *gynecology*, *edema*, and *tumor*, but we are certain that no American book of deserving character was ever misjudged or cut up in a first-class medical journal because it wrote such words in the way peculiar to its author's country. There are many works of the highest value issued by American publishers, and these are gratefully welcomed in this country, even though they use words like *pathologic* and *physiologic*, which sound a little awkward to our ears. Such books we frequently have the pleasure of reviewing in these columns, and be the spelling English or

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(*a*) *St. Louis Med. and Surg. Journal*, August, 1905.

American, we are always thankful for the opportunity of reading and praising them.

Medical Libel Action.

WHEN the Infectious Diseases Notification Act was first proposed, a good deal of opposition was manifested by some sections of the profession, and when they were finally passed not a few gloomy prophecies were made as to troubles that would arise in the future. Fortunately these prognostications have not been fulfilled, at least to anything like the anticipated extent, and all meidcal men have laboured loyally to carry out the intentions of the Act. There are, however, difficulties at times and these generally arise from the inability of a doctor to decide on the diagnosis of a particular case, and such cases occasionally find their way to the police courts. The complainants, however, seldom succeed, but the local papers are wont to nourish themselves in such occurrences to the detriment of the practitioner concerned. An enterprising journal at Accrington went one better the other day by publishing an indignant article charging a practitioner in the town, Dr. Fenwick, with professional incapacity in failing to diagnose a case of small-pox, and furthermore, with hushing up the fact when the diagnosis was established. Dr. Fenwick took the only course open to him under the circumstances by entering an action for libel against the journal in question. The case was tried at the Manchester Assizes last week. A plea of justification which had been entered by the paper was withdrawn, and all the evidence pointed to Dr. Fenwick's mistake having been an honest one. The jury took this view, and found for the Plaintiff, awarding him the exemplary damages of £1,000. We sincerely congratulate Dr. Fenwick on this happy issue out of all his troubles, and we can scarcely doubt that this result will exercise a salutary influence on local scandal-mongers wherever it becomes known. And we hope it will receive wide publicity.

Notification of Alcoholism.

Is the medical officer of health of the future to notify alcoholism as he now does scarlet fever and small-pox? We trow not, for the essentials of the two things are hardly comparable. Fortunately alcoholism is not contagious like a fever, although it may spread to an appreciable degree by the force of example. Whether the protection of the interests of the public justifies notification to eliminate the poisonous influence of the drunkard upon society is another matter altogether. Nor is it clear that the victim of alcohol will be personally better off if his vice be notified to the State. Notification, of course, connotes treatment by isolation or its equivalent, as the one without the other would be like a lock without a key. On the whole it seems likely that a better remedy than notification will have to be sought for the national curse of alcoholism. It is curious that men should turn to such remote and devious devices before they have attempted to deal with perfectly plain and obvious proposals. To take a single instance, an enormous step in advance would be taken by the stringent regulation of the quality of the alcohol sold to the public. Bad alcoholic beverages spell crime, organic disease, madness and death. Sound alcoholic drink all round would mean an immediate and vast reduction in the annual toll of disease and misery now levied upon the community by the greedy and unscrupulous liquor seller.

Anti-Vaccinators at Derby.

THERE must be something unsatisfactory about a law—or its administration—when it leads to such results as those which occurred at Derby last week. There has apparently been a determined effort made by the authorities to carry out the Vaccination Act at that place, and the local anti-vaccinators have replied by adopting a policy of passive resistance—perhaps the most awkward to deal with. Finally, twenty-six of the most obstinate defaulters were tried and committed to prison for seven days. Now as these people were all of the working class, seven days in a local gaol cannot be regarded as anything but a nominal punishment, especially as their friends outside combined to supply them with at least one good meal a day, and to maintain their families. Had a heavy fine been possible, it would have entailed great hardship, or had the sentence been a long one, the inconvenience would have been great; as it was, seven days was neither severe punishment nor complete acquittal, and the only purpose such a sentence can serve is to advertise the anti-vaccination cult. Great popular excitement was caused; meetings were held and fiery speeches made, and finally the prisoners were accompanied to gaol by processions of people singing hymns and cheering them on. Now we should say these proceedings show that nominal imprisonment is the very worst way to deal with vaccination defaulters. If the offence is considered a mild one, a fine can be imposed, or the prisoners bound over to come up for judgment, or some such way be found out of the difficulty. If, on the other hand, it is regarded as a gross fault, the law should allow a stringent penalty. As it is, these humble Derby workpeople have brought not only the practice of vaccination into disrepute, but the whole process of law, and by posing as martyrs will probably have gained many adherents to their cause. For ourselves, we would rather see no prosecutions than such as lead to these regrettable scenes.

"Dr. Bell" at Last.

THE police system of the United Kingdom, it may fain be hoped, is in a state of evolution. Just at present it appears to have reached that stage where crimes have to be manufactured wholesale out of mole-hills in order to find work for its constables. How else could multitudes of folk be imprisoned annually for sleeping out, loitering and a number of offences of most ridiculously trivial nature? Yet this sapient, alert and energetic force fails to put a stop to practices that are not only contrary to law, but are also grossly injurious to the public welfare. Year after year frauds are ruthlessly and emphatically exposed, but the perpetrators are allowed to gather in their iniquitous harvest unhindered by the police. In our own columns many years ago the practice of this "medical electrician" quack were commented upon. Yet it is only within the past few weeks that the police have made a raid upon the notorious 'Dr. Bell," of Wardour Street, London. Tons and tons of indecent literature have been seized and fines inflicted upon the proprietors. Better late than never. If the police are really bent upon doing their business, we can supply them with plenty of cases of illegal practice, some of it of a most nefarious and dastardly kind.

Infant Life Protection.

Baby-farming is one of the trades which it behoves the State to regard with a peculiarly jealous eye. It is presumably possible for it to be carried out in an upright and *bona fide* fashion, but it is surrounded with temptations of an insidious nature. The mothers who place their children out to farm are in many, if not most, cases single women in the lower stations of life, and not only can afford to pay but little towards maintenance, but find the baby a distinct hindrance to their careers. Even if honest, the knowledge that exposure of their shame will follow if they show up a person who neglects or maltreats a baby acts as a deterrent. The administration of the 1897 Infant Life Protection Act has brought officials of local authorities more closely into contact with baby-farmers than the latter have cared about, and incidentally it has convinced those officials that women who receive a single infant ought to be watched as closely as those who receive several. The Association of Poor-law Unions are about to ask the Home Secretary to receive a deputation to represent to him the desirability of reforming the law in several respects. The Association desire not only that the receivers of single children shall be registered, but that the age-limit of children received shall be raised to seven, and, moreover, that all persons adopting children shall notify the local authority under pain of fine or imprisonment. No doubt can be entertained by those who come much in contact with the poor, or indeed those who even read the newspapers, that such reforms are urgently necessary, and it is much to be hoped that the Home Secretary will see his way to meet the views of the deputation.

Proposed Membership of the Edinburgh College of Surgeons.

On Friday last a petition to institute the additional diplomas of membership was presented to the Royal College of Surgeons of Edinburgh. The petition has been organised by the Association of Medical Diplomates of Scotland, and has been signed by between 700 and 800 Licentiates and Fellows of the Edinburgh College. The main grounds on which the request for the additional qualification is based are the disqualification attached to the licentiateship in the holding of certain appointments and Poor-law emoluments, and the fact that it compares unfavourably in the estimation of the public with the membership qualification of the English college. The petition, handsomely engraved and illuminated on vellum and bound in red morocco, was formally presented to the Council of the Edinburgh College by Dr. Farrer, President of the Association of Medical Diplomates of Scotland, Dr. Bell (Honorary Treasurer), and Dr. David Walsh (the Honorary Secretary). Should the request of the petitioners be granted there can be little doubt that the College would thereby add greatly to its attractiveness and popularity among the large body of its adherents scattered not only throughout the United Kingdom, but also in all parts of the world.

Medical Inspection of the Feeble-Minded.

One of the first essentials in dealing with the feeble-minded of our Poor-law population is to form some system of accurate identification of cases. Obviously it cannot be left to the sagacity of a Board of Guardians to decide as to the fitness or otherwise of their own institution for the care of any given case of more or less pronounced feeble-mindedness. The desirability of skilled medical inspection was brought forward with admirable clearness by Mr. W. Vallance at last week's sitting of the Royal Commission, now sitting upon the whole subject. Subject to inspection and to the security it would afford, he was of opinion that the time had come when in certain cases the freedom of the individual should be to some extent restricted (1) in order to protect his or her general well-being, and (2) to protect the community against the propagation of feeble-mindness, with its tendency to pauperism, criminality, and insanity in future generations. As Clerk to the Whitechapel Union Mr. Vallance has evidently taken a serious but broad-minded view of a most important subject.

PERSONAL.

Dr. Richard Caton, Consulting Physician to the Liverpool Royal Infirmary, and Emeritus Professor of Physiology in the University of Liverpool, has been elected Chairman of the Education Committee of the County Borough of Liverpool.

Mr. J. E. Platt, F.R.C.S., has been appointed Lecturer on Practical Surgery, in succession to the late Mr. Joseph Collier, to the Victoria University of Manchester, and Mr. B. Biggar has been awarded the Junior Platt Physiological Exhibition.

Mr. John Cory, one of Cardiff's leading philanthropists, intends to establish a garden city. Five hundred dwellings are to be erected after the type of those at Bournville and Port Sunlight, and the place is to be called Corysville.

Dr. R. W. Henderson, of Ballintoy, has been appointed a Justice of the Peace for the County of Antrim.

Professor A. W. Mayo Robson, will be the Chairman at the seventh annual dinner of the London Medical Graduates' College and Polyclinic on Friday, December 8th, at the Trocadero, when a large company interested in this excellent institution is expected.

The presidency of the next International Congress on Tuberculosis has not yet been definitely settled, but it is understood that the meeting will be held in the United States of America, probably in New York.

Dr. J. Kellett Smith, J.P., of West Kirby, Chester, who died last month, leaving property valued at £68,200, has bequeathed £1,000 to the Stanley Hospital, of which he was consulting surgeon, to endow a cot in that Institution.

H.R.H. the Duke of Connaught last week laid the foundation-stone of the new wing of the Soldiers' and Sailors' Home in Eccleston Square, London.

H.R.H. Princess Christian, as president, presided last week at a meeting of the National Association for the Establishment and Maintenance of Sanatoria for Workers suffering from tuberculosis. It was stated that 31,000 of the Post Office staff had promised contributions for the endowment of special accommodation.

Mr. William Cresswell, M.P., has offered to augment the subscriptions to the endowment funds of the hospitals of Hartlepool and West Hartlepool by one-third—his contribution being limited to £3,000.

The second "Long Fox" Memorial Lecture will be delivered at University College, Bristol, on December 7th, at 5 p.m., by Professor Shingleton Smith, on "The Pathology and Treatment of Graves' Disease."

Special Correspondence.

[from our own correspondents.]

EDINBURGH.

University of Edinburgh.—Election of Assessors of the General Council to the University Court.—The result of the polling was announced on November 20th, namely, Dr. D. F. Lowe, 2,297 votes; Mr. J. Campbell Lorimer, K.C., 2,031 votes; and Dr. J. A. Traill, W.S., 1,734 votes. It may be remembered that at the statutory half-yearly meeting, Messrs. Lowe and Traill were declared elected as the result of a vote taken by show of hands, whereupon Mr. Lorimer's supporters claimed a poll—an action in which the event has justified them.

Royal Victoria Hospital for Consumption, Edinburgh.—A most successful four days' bazaar in aid of the building fund of this institution was held last week in the Waverley Market, Edinburgh, and has resulted in the gathering in of a sum exceeding £16,000. The amount aimed at was £12,000, and the promoters of the Fancy Fair have, therefore, every reason to congratulate themselves, as, after paying all expenses, there ought still to be a handsome surplus to hand over to the hospital. The bazaar has owed no small part of its success to the way in which Lady Dunedin has worked on its behalf as president of the executive committee and member of the management committee, and also to the fact that it has received support, not only from Edinburgh, but from all parts of Scotland. Among the donations received during the sale were cheques for £1,000 from Mr. Frank Usher and Mr. Crabbie.

Paisley Infirmary.—An equally successful bazaar has also been going on in Paisley in aid of the Endowment Fund of the Paisley Infirmary. It was opened on the 22nd by the Duchess of Albany, and the drawings on the first day exceeded £9,000. In this case the promoters aimed at raising £15,000, and as the sum received at the end of the third day had nearly reached that figure there is little doubt that after clearing expenses the bazaar should yield the hoped-for return. Scotland has always been known as a land where bazaars flourish, yet within one week to raise £30,000 for two hospitals by these means surely constitutes a record.

GLASGOW.

Glasgow Extra-Mural School and Royal Infirmary.—The time has long since gone by when the presence of students in a hospital ward was considered detrimental to the interests of the patients, and it is now fully realised that the more active and successful a hospital is in the subsidiary matter of clinical teaching, so much the more useful and successful will it be in its primary object of healing the sick. Consequently, it is not surprising that the authorities in the Glasgow Royal Infirmary, who have just begun to erect a great new hospital, are seriously concerned by the falling-off in the attendance of students at St. Mungo's College, and are being driven to consider whether it will be possible to ensure to the new institution that guarantee of efficiency which is alone given by teaching, or whether the future Royal Infirmary must limit itself to the duty of treating the sick. Since its foundation more than a hundred years ago the Glasgow Infirmary has been a teaching hospital, and when the University removed to the west end of the city, and the western infirmary was built, the managers of the Royal opened in 1876 a medical school (now St. Mungo's College) of their own, and not only opened it, but for twelve years contributed to it from the hospital funds. In 1889 a certain amount of endowment was obtained, and since then the Infirmary has only indirectly been connected with St. Mungo's College. Of late years, however, the number of students has steadily declined, until now the prospect of the College ceasing to exist is imminent. Under the circumstances, the Governing Board of the Infirmary and College have appointed a joint committee to consider the matter, and reports have been prepared by Dr. D. C. McVail, representing the College, and Professor Glaister, representing the Royal Infirmary. Both are agreed on practically the same solution, namely, affiliation of St. Mungo's College to the University, which would raise the status of the former body and enable it to grant degrees. Before affiliation is possible, however, a sufficient endowment of the chairs in the medical faculty is required, the necessary fund being estimated at £80,000. It is suggested that if the classes were thrown open to women as well as men, the Muirhead College Trust might contribute to this end. St. Mungo's College is to continue to exist, it seems, as though some such scheme as this must be carried out, for the causes which have led to the decline in its students are apparently not such as will become less operative as years roll on—rather the contrary. The increase in the number and efficiency of the English provincial medical schools and universities, the power which St. Andrews University has acquired of giving degrees to non-resident students, and the Carnegie Fund for paying university fees—all provide, and will continue to provide, reasons why medical students should seek to be educated elsewhere than at St. Mungo's College under the present conditions. For the sake of the school, and still more for the sake of the infirmary, it is greatly to be desired that some means should be found of prolonging its days and restoring it to its former usefulness.

Dr. McVail's report is altogether a most comprehensive one, and the whole subject is very ably reasoned out. That by Professor Glaister is less exhaustive.

Glasgow University Medico-Chirurgical Society.—A meeting of this Society was held last week in the Union. Professor Muir, M.A., M.D., who is honorary president for this year, gave an address on "Medical Science and Medical Practice." There was a large turn-out of students. Dr. Muir, in the course of his address, spoke about the advance which had been made in scientific medicine within the last thirty years. The parasite of sleeping-sickness had been discovered quite recently (in 1903) to be caused by trypanosoma, the same parasite which caused nagana, the tsetse fly disease. The mosquito which carried these trypanosomes in the case of sleeping-sickness, was Glossina palpalio. He then went on to speak about the great benefit scientific analysis was to practitioners in diagnosis, and, in passing, he said that all the medical men in the Army and Indian Service used the scientific methods in their diagnosis. He advised the students to try and cultivate a critical attitude of mind to all they read. Dr. Muir was accorded a very hearty vote of thanks for his very able, instructive, and interesting address.

BELFAST.

Outbreak of Typhoid in County Tyrone.—A very serious outbreak of typhoid has occurred in the Greencastle district in co. Tyrone, which is taxing the local resources to the utmost. The district is an isolated one, desolate and mountainous, and far from any town. The one ambulance at Omagh is quite insufficient to bring all the patients who wish to be admitted to the fever hospital in that town. Dr. Bradley, the medical officer of the Gortin dispensary district, has gone to reside in the affected area, his place at Gortin being filled by Dr. A. C. Adams. Dr. Clibborn, the Local Government Board Inspector, has been down and found twenty-five cases in one part of the district, and heard of others. He has recommended the provision of a second ambulance and a disinfecting apparatus, and has suggested the use of a potato sprayer with carbolic solution as a temporary expedient. Cases are being reported from surrounding districts, and the epidemic is evidently widespread. The Omagh Fever Hospital only accommodates about forty patients, and it is suggested that the old prison, now vacant, might be converted into a temporary hospital if necessary.

Preparing for Accidents.—The more nervous inhabitants of Belfast are looking forward with some anxiety to the inauguration of the new electric tram service this week, and their fears have not been allayed by the publication in the local papers of a series of rules to be observed by the public in case of wires charged with electricity falling in the street; the last rule reads that " animation can often be restored by treating persons suffering from electric shock in a similar way to persons rescued from drowning." The " often " is particularly suggestive!

Correspondence.

THE HUNTING OF THE DEER.

To the Editor of The Medical Press and Circular.

Sir,—I have read your article entitled " The Hunting of the Deer." I quite agree with you when you point out the inconsistency of people opposing vivisection, who themselves " sanction bearing-reins, pigeon-shooting, rabbit-coursing, hunting of tame deer, cropping of dogs' tails, the slaughter of brooding egrets to obtain decorative plumes," &c. Attention ought to be called to this subject. What right has a man who tortures a fox or otter by hunting it slowly to death, when it could be instantaneously killed—and this for mere amusement—to denounce vivisection? Such a sportsman is a vivisector himself! I am not sorry, sir, to read your strictures on sportsmen who are anti-vivisectionists. They deserve them. But, while I disapprove of torturing animals in sport, I disapprove of torturing them in laboratories with the alleged purpose of promoting the physical welfare of mankind. As to the noble aims of the vivisector which you enlarge upon, they may exist. But how does he carry them out? He puts all the pains of the thing on his poor dumb victim, while he and others take the benefit, whatever it may be, to themselves. This is cowardly and unjust. That expresses my opinion about vivisection.

You speak of researches being " under strict Government supervision." This is amusing. Practically, the licensees do what they like. They make up their own returns of experiments, and the check of an inspector is a thing they don't trouble about. Sooner or later these vivisecting cruelties will have to go, as well as cruel sports, for all such practices degrade man's moral character.

I am, sir, yours truly,
J. Stratton.

Wokingham, Nov. 20.

Obituary.

SIR JOHN BURDON-SANDERSON, F.R.S, Bart., M.D.Edin., F.R.C.P.Lond., D.C.L., D.C., LL.D.

We regret to announce the death of Sir John Burdon-Sanderson at his residence at Oxford on the 24th inst. The deceased, who was seventy-seven years of age, was the first baronet, and had been in failing health for several years. Sir John Burdon-Sanderson was descended from an old Northumbrian family. His father, Richard Burdon, the son of Sir Thomas Burdon, a wealthy brewer near Newcastle, and Jane Scott, the sister of Lord Eldon and Lord Stowell, married the daughter of Sir James Sanderson, a London merchant, whose name he assumed in addition to his own. Their son was born in Newcastle in December 1828, and was educated in the medical schools of Edinburgh and Paris. Sir John Burdon-Sanderson's attention was directed to the subject of infectious and contagious diseases, a field of investigation which he made particularly his own. His researches upon the subject of tuberculosis were in the first rank of scientific work, especially his two reports to the Privy Council in 1867 and 1868. Perhaps the chief features of his mind were the powers to unite broad views and vast knowledge with the capacity for patient, exhaustive and often brilliant experiment. Another subject to which he made solid contributions was that of cattle plague, upon which he reported to the Royal Commission in 1866. In private life he was imbued with deep religious conviction and was a member of the Presbyterian Church. In spite of his gentleness and humanity, however, he has been fiercely assailed by the antivivisectionists. He graduated M.D. of Edinburgh in 1857 and F.R.C.P. of London in 1863, and was a fellow of the Royal Societies both of London and of Edinburgh. In 1880 he succeeded in opening a new physiological laboratory at University College, London. After two years, however, he was, in spite of the determined opposition, appointed Waynflete Professor of Physiology at Oxford. This post he occupied until 1895, when he was appointed Regius Professor of Medicine at the University, in which capacity he continued to serve until advancing years led to his retirement in 1904. Sir John Burdon-Sanderson may be regarded as the founder of modern scientific medicine in the University of Oxford. In him the medical profession, not only of the United Kingdom, but of the whole world, loses a distinguished ornament.

Trinity College, Dublin, Michaelmas, 1905.

Final Medical Examination—Section B.—Ralph S. Oldham, George Dougan, Francis O'B. Ellison, Ernest D. Caddell, John du P. Langrishe, and Archibald L. Robinson, equal; William Hutchison, Reginald Holmes, and Langford V. Hunt, equal; John Gray, Michael Leahy, George G. Vickery, Francis Casement, Thomas B. W. MacQuaide.

Final Dental Examination.—Charles R. Kidd.

It is announced that the Royal Life Saving Society, which has for its object the instruction and reward of proficiency in saving the life of drowning persons, has issued no fewer than 4,177 certificates during the past year.

Literature.

MILITARY HYGIENE. (*a*)

THE author is to be congratulated on having given such a lucid account of the sanitary and hygienic problems which confront the members of the Royal Army Medical Corps, but though primarily written with this object, it at the same time appeals strongly to the civilian doctor. In many ways the problems to be dealt with by the civilian doctor and the military are similar—both have to keep large bodies of people in health; but while the chief difficulty of one is as to how to deal with the adverse hygienic conditions of war, the other has to grapple with conditions largely produced by people over whom the law does not give him a tithe of the disciplinary powers that an army officer has over soldiers; indeed, a perusal of this work may cause many a reader opposed to compulsory military service to feel that, after all, the good results of a training in discipline may well outweigh any disadvantages.

The first portion of the book deals with infective diseases, and the great lesson inculcated is cleanliness, using that word in its widest significance. The practical aims of the author preclude bacteriological details about the various diseases and rightly so, as the army officer wants to know the broad principles on which he is to act; at the same time it is a pity that when discussing dysentery there is no mention of that form of the disease produced by the amœba coli.

The chapters on water, air and food are excellent, and then follows one on refuse disposal, of which the most interesting part is the account of the "Shallow System," which is excellently described, all its advantages and disadvantages being fully discussed. Perhaps one of the most valuable chapters is the one on Alcohol: its uses as well as its abuses are very well put; and the suggestions to lessen the soldiers' temptation to drink are practical.

Throughout the book, and especially in the latter portion, one point is constantly being pressed home, viz., that for there to be an efficient sanitary service in the Army there should be, as far as possible, sanitary autonomy, and the moderate way in which the author pleads for it makes his pleading doubly strong.

The book is well got up and illustrated, but like a great many modern books, is printed on highly glazed paper, which makes it difficult to read by artificial light.

MACGREGOR ON THE PATHOLOGY OF THE ENDOMETRIUM. (*b*)

THIS volume is an entirely original work on a most interesting and important subject, which perhaps more than any other pathological condition calls for original work and new literature. Dr. Macgregor has, by the kindness of the Committee of the Laboratory of the Royal College of Physicians of Edinburgh, been permitted to examine the results of 250 curettings from the uterus, and in the pages before us she has collated the results of her examination. The book commences with an account of the normal structure of the endometrium, to which is appended a description of the changes which occur during physiological menstruation and decidua [formation. The second chapter deals with pathological changes in the endometrium, and the third and last with the classification, symptomatology, etc., of "endometritis." The latter half of the book consists of 106 excellent micro-photographs made from Dr. Macgregor's sections, and there is also a very full bibliography.

We turn with great interest to note what the writer has to say on the classification of so-called "endometritis." This is a subject of very considerable difficulty, since up to the present gynæcologists have been in the habit *more Hibernico*, of dividing what does not exist into groups "that never ought to have been." As the writer correctly says, "a true and marked endometritis, meaning an extensive inflammation of the mucous membrane, is a rare condition, and practically never comes under the pathologist's microscope for diagnosis, since, when present, it is concomitant with grave disease in the surrounding structures, and there is no necessity for examination." Accordingly, Dr. Macgregor divides the pathological changes met with in the uterus into changes in the epithelium, the stroma, and the vascular system, and recognises that a true inflammation may occur in association with any of them. Further, although the term "catarrh of the endometrium" will, she considers, serve for clinical purposes to include all cases heretofore known as "endometritis," the histologist must recognise the varying conditions which exist, and for his use the terms "congestive œdema," "adenoma," "interstitial hyperplasia," "angiosclerosis," "decidual and fœtal retention" are suggested. To each of these main divisions a modifying note as to any inflammatory, atypical, or unusual condition should be attached. Such a classification, could it become general, possesses at least the advantage of a greater accuracy than most of the classifications usually adopted. Personally, we adopt the classification of glandular, insterstitial, mixed glandular and interstitial, and hæmorrhagic or vascular, and though we confess to erring in our use of the term "endometritis," we think the classification otherwise is fairly satisfactory.

We have said enough to show that Dr. Macgregor's work is of great interest to both the pathologist and the gynæcologist, and if she succeeds in confining the use of the term "endometritis" to its proper limits, she will have done a considerable benefit to gynæcology. Will she, however, in the meantime, in a subsequent edition add to her work a list of contents and an index of both subject-matter and illustrations?

Literary Notes and Gossip.

RESIDENTS in tropical climes will, no doubt, welcome Sister Cockburn's "Practical Guide to Cookery in West Africa and the Tropics" (Scientific Press, price 3s. net). The author has had considerable experience in the Colonial nursing service at Sierra Leone, and is in a position to testify to the difficulty of providing well-cooked, salutary food. Although many of the dishes are necessarily unfamiliar to home-dwellers, they have a savoury odour and there is ample variety to choose from. The book is nicely printed and cannot fail to prove an acquisiton to the Colonial library.

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TROPICAL diseases and their treatment are now very much *en évidence*, and Sister Pollard's "Hints to Nurses on Tropical Fevers" will, no doubt, find plenty of readers. (Scientific Press, 1s. 6d. net.) To begin, the advice given is sound and practical, although we object on principle to being addressed by an author as "you," especially when the pronoun becomes obtrusive. Why, too, do authors so frequently coin the word "preventative," in preference to using the old-fashioned "preventive" (page 51)? We cannot find any authority either for the use of the word "resistive" (page 25). The description of the diseases and the directions for nursing are so admirably lucid and comprehensive that we must credit Sister Pollard with an unusual grasp of her subject. She should, however, control the tendency to go off into irrelevant rhapsodies culminating in a hackneyed verse or two.

⁂

WE are indebted to Dr. James Rodger Watson, D.P.H., for a concise and interesting synopsis of "The Life History of the Non-bacterial Parasites Affecting Man" ("Natural Science in Hygiene." John Wright and Co., Bristol, pp. 62.) The life cycle of the parasites is illustrated by ingenious diagrams and explained, as far as is known, in the text. The

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(*a*) "Military Hygiene," by Robert Caldwell, F.R.C.S., D.P.H., Lieut.-Col. Royal Army Medical Corps. London: Bailliere, Tindall and Cox. Price, 10s 6d. net.

(*b*) "A Contribution to the Pathology of the Endometrium." By Jessie M. Macgregor, L.C.P. & S., M.D., Junior Acting Medical Officer, Edinburgh Hospital for Women and Children, &c. Pp. 53, with 160 illustrations. Edinburgh and London: William Green and Sons. 1905.

number of these parasites is rather appalling, but the majority, fortunately, are foreigners.

⁂

Dr. Bridgeford Proctor's "Notes on How to Rear an Infant" (Rentell and Co., Strand.) is an excellent six-pennyworth of useful information for mothers *in posse* or *de facto*. The author, "having studied the rearing of children for many years . . . in various travels and practices," has felt justified in compiling what we may call the working details of the nursery in language which, if not impeccably grammatical, will, at any rate, be understood by his readers.

⁂

"The Radical Cure of Corns and Bunions," by Mr. F. Harding Freeland, F.R.C.S. (Bale, Sons and Danielsson), is a handy little monograph on a painful subject—so painful, indeed, as to be well worthy of the attention of the surgeon. We are all interested in the subject, directly or indirectly, and those who read this monograph will go away wiser and potentially happier men. The fact that this is a second edition shows that the author's labours have not lacked appreciation.

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The question as to whether or not we ought to continue to flog certain categories of criminals is raised by Mr. Joseph Collinson in his "Facts About Flogging" (London: A. C. Fifield). No one will contest that it is a brutal and a brutalising form of punishment, one that might receive public approval so long as the punishment of criminals is regarded as society's revenge for misconduct, but which is out of place when punishment is intended to be morally deterrent. We do not quite share the author's firm belief that flogging is less deterrent than prison, for many a man who would laugh at the idea of free board and lodging would wince at the prospect of becoming intimate with the "cat." The best argument is rather that society owes it to itself to abstain from so debasing a penalty—one that must necessarily obliterate the last trace of self-respect in the victim. As a matter of fact, however, the *lex talionis* is still the basis of our methods of criminal repression and public opinion will require to be further educated—and elevated—before it dispenses with the punishment of crimes of violence by flogging. That it ought to be abolished forthwith and completely in the army and navy is a proposition that will assuredly command universal assent.

Medical News.

The Medical Profession and Bovril.

Some thirteen hundred medical men accepted the invitation of Lord Duncannon, as chairman of Bovril, Ltd., to visit the magnificent premises of that Company in Old Street, London, on Thursday last. The visitors were conducted in parties throughout the factory, and many expressions of astonishment at its immense size, and of pleasure at the spotless brightness and cleanliness which pervaded the building, were heard on every hand. The splendidly equipped laboratories came in for considerable attention. The delicate instruments and appliances by which research work is done and raw material analysed were examined with particular interest, as all materials that enter the factory, and all goods that leave the premises are here analysed by a chemical staff to ensure a uniform degree of excellence. In another room the visitors saw the granulated beef, freed from all fat, skin and gristle, minced fine in mincing machines, and dried at low temperature, by special process, which eliminates the moisture with the least possible coagulation. It is this product, viz., the albumen and fibrine, which constitutes the chief feature of Bovril. This granulated beef is received from the Canadian factory, but before it can be used it has to be ground to a very fine powder in order to make it as nearly as possible soluble. Much interest was evinced in examining this peculiar property of Bovril, and the processes by which it was milled, and eventually passed through an extremely fine silk sieve. Large vats of liquid were also shown, each representing the beef from over 300 oxen, conveying their contents, after being thoroughly mixed, into storage tanks in the floor below from which it is drawn off directly into bottles of various sizes. As an instance of the magnitude of the undertaking, it was mentioned that in one room alone 150,000 bottles of Bovril are often turned out in one day.

Sundry other special preparations manufactured by the Bovril Company were exhibited. Of these the chief is Kudos Cocoa, and Kudos Chocolate, which is the same in solid form. The process of the manufacture of Virol, which has lately come into such prominence as a fat food in cases of Consumption, Anæmia, and Wasting Diseases, as well as a Children's Food, was also fully explained. This preparation is largely used in place of Cod Liver Oil, and contains Bone Marrow, Eggs, Malt Extract, and Lemon Juice. The reception, which included luncheon, was a great success, and Bovril, Limited, received an immense practical demonstration of the warm support accorded their product by the medical profession.

Royal University in Ireland.

Our readers may remember that the Standing Committee of the Senate of the Royal University of Ireland at its last meeting decided to ascertain from the Law Officers of the Crown whether the Senate possessed the power of punishing members of the University, if circumstances so necessitated. At the meeting of the Standing Committee, when the conduct of certain students at the recent conferring of degrees was under consideration, the legal assessor, then present, gave it as his opinion that the Senate possessed no such power. It is therefore very satisfactory to learn that in the opinion of the Law Officers, the Senate does possess such powers, who, as we are informed, have declared that it is competent for the Senate to summon before it members of the University charged with misconduct, and to inflict punishment. If this were not the case, the position of the University would be a most unfortunate one, as it would apparently find it impossible to preserve the dignity of its meetings.

Conference of Medical Officers.

A conference of medical officers of health for London, Essex, Herts, and other districts of the Home Counties was held at the London headquarters of the Incorporated Society of Medical Officers of Health when a discussion took place on the mysterious disease which often resembles scarlet fever, and as to which one suggestion is that it may be "the spotted fever." The opinion was expressed that the disease was a combination of scarlet fever and influenza, and the importance of isolation was insisted upon.

Conjoint Examinations in Ireland.

The following candidates have passed the Examination for the Diploma in Public Heatlh:—Hugh William Bailie, L.R.C.P. and S., Edin., Alice M. Barry L.R.C.P. and S.I., William Cremin, L.R.C.P. and S.I., Ragunath Vithal Khedkar, L.R.C.P. and S. Edin., William Francis Brenan Loughnan, L.R.C.P. and S.I., Connor Joseph O'Loughlin Maguire, M.D.R.U.I., Francis Joseph Moore, L.R.C.P. and S.I. John James O'Sullivan, L.R.C.P.I., L.A.H.I.

At the recent assizes, Dr. Fenwick of Accrington, sued the *Accrington Gazette* Company, Limited, for a sum of £1,000, as damages for an alleged libel published in their newspapers. The plaintiff's case was that the defendants had publicly charged him with professional incompetence in diagnosing the illnesses of two boys subsequently found to be suffering from small-pox as chicken-pox and influenza respectively. The defence was justification, and also that the words in question were fair comment on a matter of public interest. Dr. Marsden and Dr. Harris testified to the difficulty of distinguishing in some cases small-pox from some other diseases in its early stages, and the plea of justification was withdrawn. The jury awarded £1,000 to Dr. Fenwick, and judgment was given accordingly.

Notices to Correspondents, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial,* to avoid the practice of signing themselves "Reader," "Subscriber" "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

HISTORY REPEATS ITSELF.

In Biblical days there existed the "Perizites," the "Amorites," the "Canaanites," the "Hivites," and the "Jebusites"! Nowadays we have the "Paracites," the "Leucocites," the "Phagocites," and sad to say, the "Bladderemskites."—A.D.

Mr. G. J. (Merthyn Tydfil) is thanked, but the communication would be of little interest to our readers.

Os Calcis.—The matter rests entirely with the coroner, who uses his own discretion. The fact that no post-mortem examination was ordered must be taken that he did not consider an examination necessary. Our correspondent was right in recording his protest against the course while giving his evidence. At the same time the verdict shows that the jury agreed with the coroner—which by the way is generally the case.

Mr J. L. S. (Manchester).—A bond would be absolutely necessary under the circumstances.

Thos. Wilson (Cardiff).—Application should be made to the president of the college, under cover through the secretary.

Student.—We should strongly dissuade our correspondent from taking any part away from the hospital to dissect at home. We doubt the legality of the procedure irrespective of other considerations.

INFORMATION WANTED.

Dr. George M. Gould, 1722 Walnut Street, Philadelphia, asks us to mention that he will be grateful for any trustworthy information as to the methods which have been devised by the blind in overcoming their disability or in gaining a livelihood. Accounts of such lives, anecdotes, references to literature, etc., will be appreciated.

Schoolmaster (Preston).—The Education Act for 1902 undoubtedly did much good work in bringing together the sanitary and the educational authorities. But a great deal remains to be effected in the prevention of school infection. Diphtheria, measles, scarlatina, and whooping cough, each present peculiar problems. It is difficult to see how they can be excluded from schools even by the most vigilant daily inspection.

Anglo-Indian.—Hastings boasts during the quarter ending September last, the phenomenally low death-rate of 10·01 per thousand, after deducting non-residents. The zymotic death-rate was 0·47.

Dr. J. Hamilton.—Communication came to hand as we were at press, hope to utilise it in our next.

Dr. W. H. W.—The rational plan would undoubtedly be to have a bacterioscopic examination made of the discharge. You will then have a specific data for further guidance. It seems unlikely that ordinary drugs will meet the case you describe. Dr. W. O. Symes's little monograph on "Bacteriolgy in Everyday Practice" will afford considerable assistance.

Meetings of the Societies, Lectures, &c.

Wednesday, November 29th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. J. Cantlie: Clinique. (Surgical). 5.15 p.m. Dr. L. Guthrie: The Treatment of Hemiplegia and Ataxia.

Post-Graduate College West London Hospital, Hammersmith Road, W.)—5 p.m. Dr. Beddard: Practical Medicine.

Thursday, November 30th.

Childhood Society and the British Child-Study Association (Parkes Museum, Margaret St., W.).—8.15 p.m. Lecture:—Dr. F. Warner: Training of Teachers for the Care of the Feeble-minded. (Arranged by the Childhood Society.)

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. F. C. Wallis: Intestinal Neoplasms.

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Keetley: Hernia. (Lecture II.)

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Fungous Diseases of Hair: I., Hyphogenic Sycosis: II., Tinea. (Chesterfield Lecture.)

Mount Vernon Hospital for Consumption and Diseases of the Chest (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. F. W. Price: The Early Diagnosis of Pulmonary Tuberculosis. (Post-Graduate Course.)

Friday, December 1st.

West Kent Medico-Chirurgical Society (Miller Hospital, Greenwich Road, S.E.—8.45 p.m. Mr. J. Hutchinson: Skin Diseases caused by Insects. (Purvis Oration.) Conversazione. Exhibition of Electrical Apparatus, Surgical Instruments, and Books.

Society of Anæsthetists (20 Hanover Square, W.).—Paper:—Mr. J. H. Chaldecott: The Evolution of Ethyl Chloride.

Laryngological Society of London (20 Hanover Square, W.).—5 p.m. Exhibition of Cases and Specimens by W. Williams, Dr. H. Barwell, Mr. de Santi, and others.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. E. Clarke: Clinique. (Eye.)

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Dunn: Glaucoma, its Varieties and Treatment.

Vacancies.

Durham County Asylum.—Second Assistant Medical Officer. Salary £180 per annum, with rooms, board, laundry, and attendance. Applications to the Medical Superintendent, Durham County Asylum, Winterton, Ferryhill.

London School of Clinical Medicine.—Medical Superintendent of the Hospital and School. Salary £300 per annum and a proportion of the school fees. Applications to P. Michelli, Secretary, Greenwick.

Miller Hospital and Royal Kent Dispensary. Greenwich Road, S.E.—Secretary. Salary £200 per annum. Applications to the Chairman, Miller Hospital, Greenwich.

Royal Pimlico Dispensary, 104 Buckingham Palace Road.—Resident Medical Officer and Secretary. Salary £100 per annum, unfurnished house and percentage. Applications to the Secretary.

Royal Hospital for Incurables, Donnybrook, Dublin.—Resident Medical Officer. Salary £120 per annum, with board and furnished apartments. Applications to John J. Thompson, Registrar.

The Victoria Hospital for Burnley and District.—Resident Medical Officer. Salary £100 per annum, with residence, board and washing. Applications to F. A. Hargreaves, Honorary Secretary, 7 Grimshaw Street, Burnley.

Bethlem Hospital.—Two Resident House Physicians. Honorarium of £25 per quarter, with apartments, board and washing. Applications to the Treasurer, Bridewell Hospital, New Bridge Street, E.C. (See Advt.)

County Asylum, Dorchester.—Second Assistant Medical Officer. Salary £180 per annum. Applications to the Medical Superintendent.

Tunbridge Wells General Hospital.—House Surgeon. Salary £100 per annum, with board, furnished apartments in the hospital, gas, firing, and attendance. Applications to the Secretary.

University of Durham College of Medicine, Newcastle-upon-Tyne.—Demonstrator of Physiology.—Salary £200 per annum. Applications to Professor Howden, Secretary of the University of Durham College of Medicine, Newcastle-upon-Tyne.

York City Lunatic Asylum.—Assistant Medical Officer. Salary £140 per annum, with board, residence, attendance, and washing. Applications to R. Percy Dale, Town Clerk, Guildhall, York.

West Riding Asylum, Wakefield.—Pathologist and Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Director.

Whitehaven and West Cumberland Infirmary.—Resident House Surgeon.—Salary £120 per annum, with board and lodging. Applications to W. H. Sands, Secretary.

Appointments.

Archibald, R. J., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Chelsea Hospital for Women, Fulham Road, London, S.W.

Burgess, Arthur H., F.R.C.S.Eng., M.B., M.Sc.Vict., Honorary Assistant Surgeon to the Manchester Royal Infirmary.

Campbell, Donald, M.D., C.M.Glasg., Medical Officer of Health of Calne (Wilts).

Fisher, Theodore, M.D.Lond., M.R.C.P.Lond., M.R.C.S., on the Honorary Medical Staff of the East London Hospital for Children, Shadwell.

Groves, Ernest J. C., M.B., Ch.B.Edin., House Surgeon at the Swansea General and Eye Hospital.

Hewkley, Frank, M.B.Durh., F.R.C.S.Eng., Clinical Assistant to the Western Ophthalmic Hospital.

Mullin, John, L.R.C.P. & S.Edin., Medical Officer of Health of Strokestown, Ireland.

Pearson, J. Sydney, M.B.Cantab., M.R.C.S., L.R.C.P., Senior Resident Medical Officer at St. Mary's Hospital for Women and Children, Plaistow, E.

Short, Arthur Rendle, M.D., B.S., B.Sc.Lond., House Surgeon at the Bristol Royal Infirmary.

Smith, H. Hammond, M.R.C.S., L.R.C.P.Lond., a Medical Referee under the Workmen's Compensation Acts, 1897 and 1900, and to act for Brentford, Brompton, and Marylebone County Courts in County Court Circuit No. 43.

Births.

Hudson.—On Nov. 20th, at 3 West Cliff, Dawlish, the wife of Captain Corrie Hudson, D.S.O., I.M.S., 2nd Q.O. Rajput L.I., of a daughter.

Marriages.

Drewry—Grimes.—On Nov. 25th, at Marylebone Parish Church, London, Edward Gwyther, second son of the late George Overend Drewry, M.D., Surbiton, to Ethel Winifred, elder daughter of Walter Grimes, Esq., Finchers, Amersham, Bucks.

Hardie—Wall.—On Nov. 22nd, at St. Mark's, Southampton, Frederick Hardie, M.B., Ch.B.Edin., of Bentham, Yorkshire, to Elsie May, youngest daughter of Thomas J. Wall, of Brookwood, Southampton.

Deaths.

Adamson.—On Nov. 25th, at Hetton House, Hetton-le-Hole, co. Durham, Norah Penelope, youngest and beloved daughter of J. Adamson, M.D., aged 24 years.

Fell.—On Nov. 24th, at 9 Cheverton Road, Hornsey Lane, Lucy Grayson Fell, the dearly beloved wife of the late Jesse Weldon Fell, M.D.

Jones.—On Nov. 21st, at River House, Enfield, Philip William Jones, L.R.C.P., M.R.C.S., of pneumonia following Influenza.

McNeill.—On Nov. 19th, at Lynton, Hook Road, Surbiton, Patrick McNeill, M.D., formerly of Sydney (New South Wales), aged 55.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, DECEMBER 6, 1905. NO. 23.

Original Communications.

HÆMATOMA OF THE OVARY,

AND ITS PATHOLOGICAL CONNECTION WITH THE RIPENING AND THE RETROGRESSION OF THE GRAAFIAN FOLLICLE. (a)

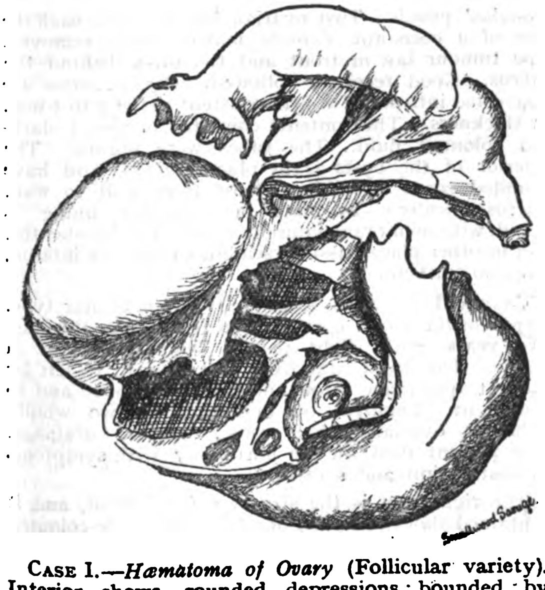
By SMALLWOOD SAVAGE, M.B. OXON., F.R.C.S.,

Surgeon to the Birmingham Lying-in Charity and Wolverhampton Hospital for Women.

THE usual classification of hæmorrhage into the ovary is: (1) Interstitial or "apoplexy"; (2) Follicular; and (3) into the Corpus luteum. While interstitial hæmorrhage occurs in several of the cases below described, alongside the other forms, I have considered that it results secondarily. I have not touched upon hæmorrhage, such as occurs in the twisting of an ovarian tumour or in acute specific fevers. My excuse for bringing forward this subject is that hæmatoma of the ovary, especially of the follicular variety, does not seem to have been hitherto sufficiently explained in gynæcological literature.

CASES.

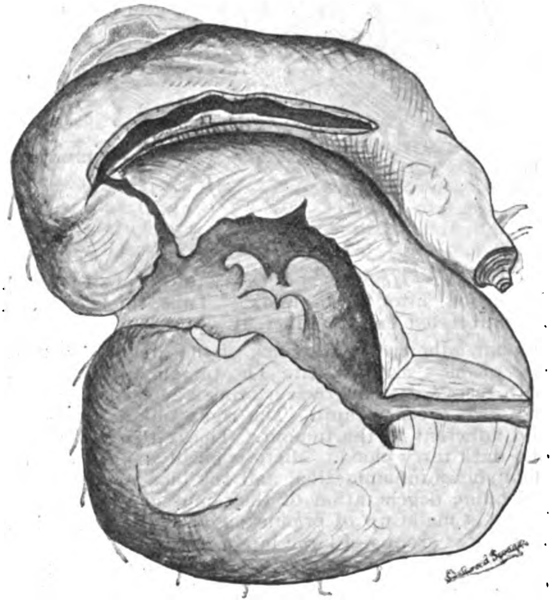
CASE I.—Æt. 33, single. Severe pain in right side seven months, periods regular, no discharge. Lump felt on right side of uterus. Pain became worse under expectant treatment during four months. Removal with good result. Uterus contained a small subperitoneal fibroid the size of a pea. The left ovary was cystic, but not removed.



CASE I.—*Hæmatoma of Ovary* (Follicular variety). Interior shows rounded depressions bounded by cord-like ridges, being remains of distended follicles and partitions between them.

Pathology.—The right ovary is converted into a blood cyst the size of a tangerine orange; small multiple adhesions with small portions of blood-clot are seen on the surface. The Fallopian tube and mesosalpinx are healthy. The contents were dark and black fluid. The wall of the cyst varies in thickness from a thin transparent membrane up to 7 mm. The interior of the cyst is uneven, and shows rounded depressions bounded by cord-like ridges; free bands stretch across the cyst and are the remains of partitions between distended follicles before the rupture into the main cyst. Microscopically:—The cyst is lined by cubical epithelium, under which lies a layer of cells indistinguishable from the theca interna of a developing Graafian follicle.

CASE II.—Æt. 18, single. For two years had to go to bed during the menstrual period on account of pain which occurred during and after the flow. The pain was felt in the left lower abdomen. The hymen was present. A tumour, the size of a fœtal head, was felt in the region of the left ovary. The tumour was removed; it was very adherent to omentum and to the sides of the pelvis. Thick, brick-red altered blood was contained in the main cyst; other cysts burst



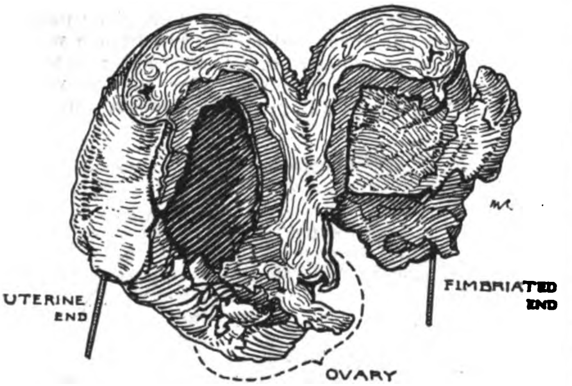
CASE II.—*Hæmatoma of Ovary* (Follicular). Walls of varying thickness, interior uneven. Tube thickened and opening into ovarian cyst to form a tubo-ovarian cyst. Microscopically: the lining of cyst shows a multiple follicular cyst formation.

(a) Paper read before the British Gynæcological Society on November 9th, 1905.

during extraction which contained either altered blood or thin clear fluid. Recovery followed for a time, but later a hæmatoma formed which had to be opened through Douglas' pouch. Ultimately recovery followed. The tumour is a tubo-ovarian blood cyst. The Fallopian tube opens widely into the cyst of the ovary. Both ovary and tube are thickened by inflammatory deposit and œdema. Microscopically :—The ovarian tissue shows marked signs of inflammation, the vessels are congested and scattered lutein cells are seen apart from the ripening follicles ; the lining consists of a single layer of cubical epithelium arising from many small follicles which are prematurely ripening and bursting into the main cyst. The formation of the blood cysts can be traced by observing the small epithelial-lined, lancet-shaped unruptured cyst with their accompanying newly-formed blood-vessels and prematurely developing lutein cells in the theca interna up to the open-mouthed clefts which have ruptured into the interior of the cyst and have discharged their contents therein. Many accompanying vessels are seen on the point of bursting and of contributing to the blood of the cyst.

Case III.—Æt. 28, married. Illness began eight months before, or a fortnight after her first confinement. The puerperium was normal up to the fourteenth day, when pelvic inflammation began. For some months I treated her medically, but finally I removed a fixed tumour of the right ovary the size of a tangerine orange. The right tube was inflamed, thickened and tortuous, and the ovary contained a large solid clot giving the appearance of an excessive hæmorrhage into a corpus luteum. Microscopically :—No lutein tissue could be seen. Recovery followed.

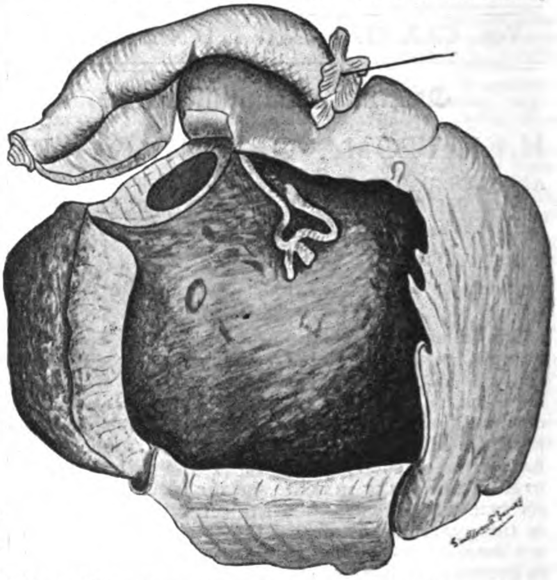
Case IV.—Æt. 33, married ; three children ; last three years before. Was taken with sudden pain in right side two weeks after a period. A hard, nodulated tumour adherent to the back of the uterus about the size of one's fist was felt. The tumour was removed, with recovery. The ovary forms a blood tumour the size of a green walnut. The right tube is congested and adherent to the tumour. The contents consisted of a dark tarry blood. Microscopically :—The ovarian shell shows inflammation, and the blood-vessels show a hyaline degeneration of their muscular coat. The lining is made up of organising fibroblasts, and in a few places groups of large lutein cells.



Case IV.—*Hæmatoma of Ovary* (of Corpus Luteum). Extension into mesosalpinx. Tube thickened and its fimbriated end is adherent.

Case V.—Æt. 29, married thirteen months ; no child. Slight abdominal pain for ten months with white discharge (but not of a smarting character). The uterus was fixed, and two wholly adherent ovarian blood cysts the size of tangerine oranges were removed. Recovery followed. The left ovary is unilocular and contained thick tarry fluid. The left tube was red and injected when fresh, and its abdominal ostium gaping and free. The right ovary contains three or four cysts, with their contents thin, or else thick and tarry. Microscopically :—The left cyst shows blood extravasation under the lining, the blood appears to be undergoing organisation through the medium of large cells, which become filled with coarse yellow pigment granules. The right cyst contains one cavity lined by a folded lutein layer, while another cavity is lined by what is seen in a Graafian follicle, and there are other irregular spaces in ovarian stroma itself.

Case VI.—Æt. 30, married ; two children ; last four years before. History of sudden attack of severe pain in abdomen twelve months before, with vomiting. Pain came on after going to stool. Attack lasted four days. A tumour was noticed eight months afterwards, rising as high as the umbilicus and filling Douglas' pouch. Two ovarian blood cysts, each the size of a cocoanut, densely matted, were removed. One tumour lay in front and the other behind the uterus. Good recovery followed. Both ovaries are converted into shells of firm resistent tissue 2 to 5 mm. in thickness. The contents consisted of viscid, dark-red coloured fluid. The tubes were normal. The interior of the cysts is in places pitted, and have rounded cords stretching across from wall to wall. Microscopically :—In places a follicular lining is noted, with membrana granulosa and follicular sheaths, and in other places tissue resembling the theca interna, with no epithelium.



Case VI.—*Hæmatoma of Ovary* (Follicular). Walls are of varying thickness ; in places they are thick and œdematous and contain extravasated blood (as shown). Bands are seen stretching across cyst (being remains of partitions between original discrete follicles).

Case VII.—Æt. 29, single. Strong, muscular type. Menorrhagia from commencement ; worse the last two years, with slight pain. Tumour noticed in pelvis. The uterus was fixed and inclined to left by the left appendage below and the right above and to the right. Removal by operation of two wholly adherent ovarian blood cysts ; vaginal drainage. The patient died on the ninth day with symptoms of obstruction and sepsis.

The right cyst is the size of a fœtal head, and it contained about two pints of a thick chocolate-coloured fluid, its lining is uneven, soft and brown-stained, and its wall of varying thickness—2 to 10 mm. The left cyst is smaller, about the size of an orange, and contains two loculi. The right tube is open at its fimbriated extremity and not adherent ; the right tube is just adherent to the ovary. Neither tube is more than a little thickened by œdema. Microscopically :—The lining shows fibroblastic tissue in process of organisation, but in between strands of fibrous tissue are many large irregularly-shaped cells, but for the most part these are cuboidal or rounded. These cells present refractile, coarse granules, and their nuclei are relatively small, and in some cells are crowded towards the periphery.

In considering all these seven cases of hæmatoma of the ovary, and in order to arrive at some conclusion as to their nature, it will be necessary to examine their clinical histories and pathological conditions, macroscopical and microscopical.

Age.—The average age was 28·5, the oldest being 33, and the youngest 18. Three of the patients were single and four married. Menstrual history: Menorrhagia occurred in two cases; in the others it was normal and regular. Dysmenorrhœa occurred to a more or less degree in all of the cases. In no case was there any cessation of menstruation. Leucorrhœa was prominent in one case.

Pain was an almost constant symptom; in three cases it came on suddenly and acutely; in one of these there was severe pain with vomiting after going to stool, twelve months before. In the other cases it came on gradually. The length of illness extended into months and years.

In the seven cases the hæmatoma was bilateral in three. It occurred on the right side in three, and on the left side in one case, where the tumour was unilateral. Tubal disease:—No hydrosalpinx or pyosalpinx was found in any of the seven cases. The Fallopian tubes are healthy in four, in three of which the ovary was affected on both sides. In the remaining three cases there is a thickened salpingitis; in two of these the fimbriated extremities are adherent, and in the third the tube communicates by a broad opening to form a a tubo-ovarian blood cyst. No tubercle was found, nor was there anything to suggest tubal gonorrhœa.

Adhesions.—These were prominent in all the cases; they presented considerable difficulty in their separation from uterus, intestine and sides of pelvis, as they were thick and vascular. The contents varied slightly from a thin watery blood-stained fluid, which was contained in a few secondary cysts in the walls of the large ones, to a viscid, tarry, chocolate-coloured liquid mass, which was especially noticed in the older cysts. The cysts were ruptured in extraction in all the cases.

Classification.—Group I.

Cases I., II., V. (right cyst), and VI.—Hæmatoma occurring at an early stage in the ripening of the Graafian follicle; the membrana granulosa is represented, also the theca interna, with the lutein cell and the vascular fibro-cellular theca externa.

Group II.

Cases III., IV., V. (left cyst), and VII.—Hæmatoma occurring at a late stage in the ripening of the Graafian follicle. The lining may show either fully-developed or retrogressive lutein cells, or else a fibro-blastic tissue that has displaced or is in the process of displacing them. It will be necessary to examine these groups more in detail.

Group I.—*Hæmatoma of the Graafian Follicle.*—The blood cysts in this group are fitted by circular, shallow depressions in the lining with rounded edges, and they have rounded cords or bands stretching across the cyst. These pits and bands indicate the remains of MANY original follicles, with their partitions between them, and the unilocular character of these cysts has been produced by the rupture of many into one another. From this the process would seem to be a multiple follicular cyst formation. Now, before we define our position further, let us examine more carefully the lining of the cysts.

In the four specimens which have been mentioned as coming under this heading I find that under the microscope the blood-vessels which are in association with the follicles of the lining to be either on the point of rupturing or to give an appearance that they have already ruptured into the blood cyst. Some vessels appear to be approaching the interior of the cyst and closely connected with an enlarging follicle. Some vessels are covered by and only separated from the interior of the cavity by a single layer of epithelium, the membrana granulosa, and some have their lumina open to the cyst. The lining of these four cysts show a broken single layer of epithelium; it is absent for the most part, but where present it is sufficiently characteristic to enable one to recognise its nature (membrana granulosa). The fact that it is single-layered and generally cuboidal shows probably a metaplasia, besides which the cells in one section appear irregular in shape, with phlange-like processes. This layer of cells, when present, lies on the basement membrane or membrana propria. Beneath lie two layers of tissue which, to all appearances, correspond to the theca interna and the theca externa; both these layers are vascularised, especially the former. The cells of the inner layer show the early lutein cell formation. In the cysts of Cases II. and VI. the lining exhibits microscopically MANY follicles, some of which are entire and are approaching the interior of the cyst, whereas others have opened into and widely communicate with the cyst cavity. In some of these follicles the membrana granulosa is many-layered. Accompanying these follicles, towards the cyst interior, lutein cells are easily made out in the surrounding sheath; so also are congested blood-vessels. For some reason lutein cells are scattered diffusely throughout the section and constitute an "excess" in Case II.

The reason of the follicles rupturing internally into one another and not separately at prescribed intervals (monthly) on to the surface of the ovary is perhaps a somewhat complicated question; it is probably due chiefly to the acceleration given to the growth of many follicles simultaneously by the congestion of the ovary in general and of the vascular wreath of the individual follicles in particular, together with their failure to travel towards the periphery of the ovary. It is probable that the blood supply controls and determines, to a large extent, the growth of the follicles and their periodical maturation and retrogression in their normal state, also that hæmorrhage does not take place into the follicle until it is fully ripe, and when the follicular sheath (lutein layer) has so developed as to be able to limit the amount by its contraction (as shown by its puckering). Further, the lutein layer may, when properly developed, act as a means for vascularising the follicle in its travel towards the surface of the ovary prior to its rupture. Pathologically, and in these cases of follicular hæmatomata, it would seem that, abnormal congestion of the ovary occurring from whatever cause, MANY follicles prematurely develope at the same time and hæmorrhage takes place partly into immature follicles and partly into the stroma of the ovary, which, by its extent and situation, is impossible of removal by a want of development of the lutein layer. Failure to travel towards the periphery of the ovary may be explained by the same want of full development of the lutein layer. Congestion of the blood-vessels of the ovary may be brought about either by inflammation of the ovary or by a general pelvic hyperæmia, such as may occur in uterine disease (as fibroids) or by a sudden increase of vascular tension at the time of the physiological ripening of the follicle. I have reason to believe that these causes of congestion of the ovary have been the determining causes of the MULTIPLE cystic formation in the several cases of my series of hæmatomata (follicular hæmatomata), but of these causes I regard the hyperæmia due to inflammation as being the most potent.

As another reason why the contents of a follicle or a number of follicles do not rupture externally, it may be urged that, the ovary being inflamed and adherent as each of these have proved to be at the operation, the thickened capsule may prevent the normal discharge of follicular contents into the peritoneal cavity, or else, apart from primary inflammation of the ovary, if the hæmorrhage within the follicle is greater than normal, or is continuous, the tunica albuginea may contract so as to close the rent after the ovum has been discharged.

All the follicles which are near to the lining of the blood cyst and which appear to be approaching the interior are devoid of ova, and thus it might well be held that the absence of the presiding ovum, which might have been due to inflammation around that follicle, is the cause of the arrest of its development, and, further, of its failure to approach the surface for rupture. The absence of ova in follicles may be accidental, in that the section has not hit it off, or else in the hardening or preparation of the section it has been lost or destroyed.

GROUP II.—*Hæmatoma of the Corpus Luteum.*—This group will include those blood cysts which arise at a stage in the life history of the Graafian follicle after the lutein cells have become fully developed. Lutein cells may be present or absent in the tumours of this group according to the time that has elapsed since the retrogression of the follicle commenced, whether it has ruptured externally into the peritoneal cavity or not, and also according to the extent of the inflammation present.

Specimen from Case III. is an example of a corpus luteum in which the hæmorrhage into the yellow body has been excessive. The condition arose in connection with puerperal fever, which started fourteen days after the first confinement eight months before. The blood forms a solid clot.

The tumours from Cases IV., V. (left side), and VII. may be placed in this group. These tumours vary in size from that of a green walnut to that of a fœtal head. Dense adhesions were present in all. The tumours are cystic. The walls are thickened, œdematous, and stained with blood extravasations. The contents were all of the same character, viz., thick, grumous, chocolate-coloured fluid. The interior of the cysts shows a ragged, uneven, and deeply-stained lining of a chocolate colour. Microscopically, there is an outer shell of ovarian tissue, which is for the most part congested; the inner part of the wall shows newly-formed fibrous tissue, poor in cells, and near to the lining in between longitudinal strands of this tissue there are blood extravasations, many round cells, and many large rounded or cuboidal cells containing yellow coarse granules. The nuclei of these cells are relatively small, and in many instances seen to be crowded towards the periphery of the cell.

The blood cysts of the ovary, as just described, are not to be taken to include the ordinary follicular cysts, which are met with in the condition of peri-salpingo-oöphoritis, and which may or may not contain blood, or, indeed, the small follicular cysts which are met with in sclero-cystic disease of the ovary so-called. These cysts vary in size, ranging from that of a pea up to that of a hen's egg; they are discrete and do not tend to communicate with other cysts of the same nature to form a single cavity. Their contents are thin and watery, and are often blood-stained. The lining shows a velvety mucous surface appearance. The ovarian tissue is often chronically inflamed, and is œdematous to a greater or less extent. It is a noteworthy feature that on puncturing the thin walled multiple cysts in the ovary, the subject of oöphoritis (as in the condition of peri-salpingo-oöphoritis), the size of the collapsed organ is much about the same as a normal ovary, whereas in hæmatoma of the ovary, should the cyst be ruptured, as during extraction, the cyst wall, being especially thickened with not merely œdema but with round cell infiltration and blood extravasation, stands out as a firm, indurated, non-collapsible shell. This gross difference marks an important distinction between the two conditions.

It might be asked whether uterine fibroids are at all concerned in the production of hæmatoma of the ovary. Twelve months ago, at this Society, Dr. Bedford Fenwick read notes of a case of uterine fibroids with bilateral hæmatoma of the ovaries; both ovaries were converted into blood sacs, the one containing 8 ozs. of black blood and the other 4 ozs. At the same meeting, Dr. Heywood Smith showed a uterus containing numerous fibroid tumours, one in process of sloughing; in this case the right ovary was converted into a large blood sac. Commenting on these specimens, Professor Taylor said that he had occasionally, but only occasionally, found large blood cysts of the ovary in association with myoma of the uterus. In the *American Journal of Obstetrics*, August, 1905, Bovée makes a comprehensive analysis of the degenerations and complications of 1,398 cases of uterine fibroids, that have been operated upon and reported by Noble, Cullingworth, Ellice M'Donald, August Martin, Frederick, Scharlieb, Hunner, and Webster, and out of this large number of cases only one case of hæmatoma of the ovary is tabulated.

In the seven cases of hæmatoma of the ovary which I am presenting, two had very small subperitoneal fibroids. If, however, hæmatoma of the ovaries does not occur in connection with fibroids more frequently than 1 in 1,398, the association is no more than coincidence, but if more cases occur which are not reported then the matter would have to be investigated.

Summing up, then, the nature of these ovarian hæmatomata, I would say that the first group result from a multiple and premature ripening of Graafian follicles, which is most probably due to inflammation of the ovary, that an outpouring of blood takes place into these follicles from the vessels of the thecæ internæ, that the cysts unite, and that, being immature (possibly by reason of the absence of the presiding ovum), the normal retrogression of the follicle does not take place, and a blood cyst remains. It may be noted that the pathological condition of these blood tumours and of the amount of the fluid contents in them is brought about more by the rupturing of blood-vessels than by the enlargement and subsequent bursting of any follicles. In the second group the blood cysts are lined by inflammatory fibro-blastic tissue, in which may be embedded remains of fully-grown lutein tissue, and therefore these tumours may be said to have arisen during the retrogressive stage of the Graafian follicle, and may be called hæmatomata of the corpus luteum.

I would point out the main features of hæmatoma of the ovary:—

1. The disease occurs in the first half of menstrual life, in the single and the married.
2. The disease tends to be bilateral, and appears not to be associated with gonorrhœa or tubercle, but may be caused by certain forms of septic infection, but more evidence is needed.
3. The onset may be acute, but the pain becomes chronic, and is located in the lower abdomen. The general health is affected later.
4. Menstruation is not affected, though there may be slight menorrhagia. Dysmenorrhœa may occur.
5. There is a marked disorganisation of the ovary, converting it into a shell of ovarian tissue of very varying thickness, and containing dark chocolate coloured blood, generally of a viscid character.
6. Broad adhesions to surrounding parts are always present, being an indication of inflammation of a more or less severe nature. The adhesions are more marked where the tumour is thinnest.
7. The Fallopian tube more often than not shows no gross changes, although primarily it is possible they were inflamed. The relative freedom of the tube is in marked contrast to what obtains in the ovary.
8. The lining of the cyst may show rounded depressions, being remains of many distended follicles.
9. Microscopically, the lining may correspond to what is found in the developing Graafian follicle, viz., membrana granulosa, theca interna with lutein cells, and theca externa, or to what is found during its retrogression.

Finally, I thank Professor Taylor for permitting me to make use of and to include one of his cases into my series, and also for the kind help he has given me in the consideration of this subject. I would also thank Professor Leith, who has kindly placed the Pathological Laboratory at the Birmingham University at my disposal for the working out of these cases, for without this opportunity I should not have been able to have presented this paper.

NOTE ON THE APPLICATION AND USE OF

MICHEL'S SKIN CLIPS,

FOR THE

CLOSURE OF SUPERFICIAL WOUNDS.

By W. I. de C. WHEELER, M.D., F.R.C.S.I.,
Surgeon to Mercer's Hospital, Dublin.

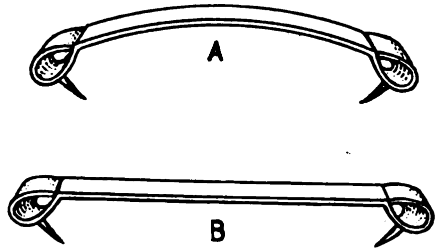


Fig. 1.—Straight and curved clips, the latter being the proper form.

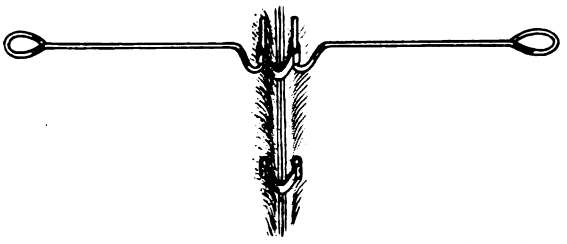


Fig. 2.—Skin edges pinched up, showing insertion of clips.

Now that the application of Michel's skin clips has been resorted to more generally in surgery for the closure of superficial wounds, a short note on their application and uses as a means of skin suture may not be uninteresting. I have used them in all operations, unless in those few to be mentioned below (in which their use was contra-indicated) for the past fourteen months. At present, I am only aware of a few conditions, and these do not often arise in everyday surgical practice, in which the use of Michel's clips as a means of closing a wound is precluded. Of these conditions, the first and most obvious arises in operations, such as removal of the breast, where the skin edges can only with difficulty be approximated and the clips cannot therefore be introduced with facility. Even if their application be accomplished, their strength would not be sufficient to hold the edges of the wound, which are under tension, in correct apposition. Again, it is better to avoid the use of the metal sutures if it is found necessary to pass any supporting suture immediately under the integument, for, in this case, the edges of the skin during the introduction of the clips cannot be pinched up with the index finger and thumb in the manner necessary for their introduction. In consequence, much delay is occasioned, and one of the main advantages of the clips, viz., speed, is lost. Similarly, in all operations where the two skin edges cannot be raised up with the finger and thumb, it is advisable to abandon the metallic clips for one of the older forms of suture, especially the subcuticular. As an example of an operation, where the two skin edges are not under tension, and yet cannot be approximated in the manner necessary for the quick application of Michel's clips, may be mentioned excision of the upper jaw. In this operation I found that the margin of the wound next the eye, nose, and middle of the lip was fixed to the subjacent bone to an extent that prevented the two edges of the wound being held up together, and so interrupted sutures of silk-worm gut in these cases were found more suitable. Having enumerated a few of the objections to metallic clips as a form of suture, I will now pass on to the advantages to be gained by their use, and at the outset I would like to record my belief (having used the clips with the greatest satisfaction now in some fifty or sixty major and minor operations) that in many respects they are superior to any form of suture for uniting the skin wound, provided always that they are properly used. Amongst the advantages to be gained by the employment of Michel's clips are the following :—

1. They are surely and easily sterilised.
2. They are more rapidly introduced than any form of suture.
3. They can be painlessly inserted in wounds caused by accidents, &c., where there is no anæsthetic, or in minor operations where local anæsthetic is used.
4. There is no pain attending their removal.
5. The scar which remains after their withdrawal is scarcely visible.
6. There is an easy escape into the dressings of all serum, &c.
7. The same clips can be used repeatedly.

Introduction of the clips.—Before commencing to close the wound it should be ascertained that the clips about to be used are of proper manufacture ; sometimes those supplied are far too flexible, bending under the least pressure like fine wire. This point can be tested when purchasing the clips by catching one of them between the finger and thumb ; it should not bend until an appreciable amount of pressure (the exact amount can soon be learned by experience) is employed.

Again, the metal clip should be gently curved and not straight (Fig. 1), so that when the introducing forceps is applied they will not bend with a sudden "snap," but close gently into place.

For similar reasons, once the suture is in place no extra squeeze of the forceps is necessary to tighten them ; the clips will hold the skin edges in contact, without undue pressure of the introducing forceps. The forcible squeezing of the clips is accountable for the marks seen in some cases on either side of the scar, after their employment. These marks are never more noticeable than those which remain after a needle has passed through the skin, but they can be avoided altogether with ordinary care.

Three methods may be employed to introduce Michel's sutures : (1) One introducing forceps is used and loaded by the surgeon himself from a row of sutures arranged on wire bent like a hairpin, and held in a convenient position by the attending sister. (2) Two introducing forceps are at hand, the sister loading one while the surgeon is using the other. (3) A self-loading magazine instrument. Of these three methods I have seen Roux, of Lausanne, use the first. He very rapidly reloaded the forceps from a supply held on a hairpin by the theatre sister after the introduction of each clip. The second method I have up to quite recently employed myself, the sister always having a recharged forceps ready after the introduction of each suture, and so no time is lost. The magazine instrument I have recently employed, and for rapidity and convenience it completely surpasses the other two methods. The instrument is most ingenious, it comes to pieces to facilitate cleaning with the greatest ease, and, considering that it is really little less than a sewing machine, it is not very complicated. I have found that my own instrument

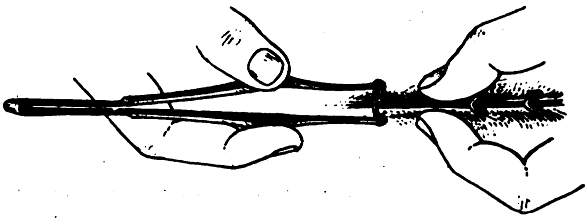


Fig. 3.—Removal of clips with wire hooks.

requires a little adjustment before the forceps can be made to seize the clip in a straight manner and also in order to allow the escape of the clips at the right moment; otherwise several may fly off the machine before one can be gripped, and, on the other hand, the clip may be so gripped that it will not be released at all. The adjustment of one small metal plate at the back of the instrument remedies these defects, yet the possibility of a "miss fire" with the magazine instrument makes me still favour the use of two introducing forceps, instead of the self-loading instrument.

Removing the clips.—The clips should be removed on the fifth day in the majority of cases. This is accomplished by the use of the two hooks which are supplied for the purpose. These hooks are inserted into the two little holes at the sides of the sutures and gentle traction applied so as to straighten them; then, before finally lifting the clip away, it is gently moved from side to side to disengage the lateral spikes from the skin. The fold of skin which was raised by the insertion of the clips on their removal disappears, and practically no mark remains, provided the sutures were not introduced too tightly. A forceps made for the purpose may be used to remove the sutures instead of the wire hooks.

A suitable dressing for the wound after removal of the sutures is a paste made of bismuth subnitrate and corrosive sublimate painted on with a sterilised brush. To prevent stretching of the scar the latter should be supported for at least fourteen days either with strapping or a suitable collodion dressing. The scar being only five days old is weak and liable to stretch if unsupported; nevertheless, it is wise to remove the clips at that time if the least possible mark in the skin is to remain.

THE
FAMILY CARE OF THE INSANE:

WITH REFERENCE TO THE PROBLEMS WHICH ARISE IN IRISH LUNACY ADMINISTRATION.

By CONOLLY NORMAN, F.R.C.P.I.,
Resident Medical Superintendent, Richmond Asylum, Dublin.

(*Concluded from page* 560.)

After what we have already said, it must then be evident that nobody can afford to admit nowadays that he has examined the subject and that he questions the feasibility of family care of the insane. The time when it could be pretended that the evidence pointed to this method of dealing with patients as being only suitable for the Dark Ages, or for particular localities, or for a class of cases so limited as to be unworthy of consideration, is past. The method has worked and does work very extensively under a great variety of conditions. The *onus probandi* now rests on those who maintain that in any special place there exist insuperable difficulties in the execution of a system which experience in so many other localities has proved to be not alone workable but also beneficial, inasmuch as it is humane towards the insane who are its subjects, advantageous to asylums which it disencumbers, practically free from danger, and profitable to the poor who take charge of patients under its provisions.

The practical points to be considered are, first, that claim on the part of the advocates of family care which we have not yet dwelt upon, namely, economy; secondly, how could the system be legalised in Ireland, and under which variety could it be carried out; and, thirdly and lastly, what are the difficulties as to its adoption specially existing in this country, if such there be?

Although economy should not be allowed to stand in the way of a movement which is, directly or indirectly, for the benefit of all classes of the insane, yet there is little chance of gaining immediate popular sympathy if we cannot appeal to interests which centre in the ratepayers' pockets. It is fortunate, then, that all evidence goes to show that the maintenance of patients in family care is materially cheaper than in asylums. Indirectly a system which prevents the engorgement of asylums and consequently the constant enlargement of cramped old, and the erection of extensive new, buildings tends to a great saving in capital expenditure. Excluding this consideration, however, we find a remarkable saving in those day by day expenses which are classed under the head of maintenance. In the Scotch Blue Book for 1903, the Commissioners, while admitting the difficulty of exactly reckoning the capital cost of asylums at per patient, owing to the varying price of buildings, land, &c., and to the varying numbers actually under treatment in institutions, were yet able, by bulking the amounts annually repaid and dividing the total as if it were rent, to estimate that per bed the insane who were rate-supported cost the country a rental of £17 9s. 3d. The 2,650 patients or so in family care would thus cost the country close on £50,000 a year in "rent" (*i.e.*, capital charge), if they were to be accommodated in asylums. The maintenance cost can be more definitely calculated. In a paper read at the International Home Relief Congress in Edinburgh in 1904, Dr. Charles MacPherson, Deputy Commissioner in Lunacy in Scotland, says:—"From the latest statistics in our possession, I find that the average cost per patient in private dwellings is 6s. 10½d. per week, while in institutions it is 10s. 7¾d." Thus the patients in family care cost nearly one-third less in Scotland than those in asylums.

In the immense colonies of the Department of the Seine, which have developed with such marvellous rapidity and success since they were initiated by Dr. Marie in the autumn of 1892, and which provide now for 1,500 patients, the cost is, roughly speaking, one-half of that of the closed asylums of the department (1 fr. 40c. per day at the Colony of Ainay-le-Château; 1fr. 60c. at the Colony of Dun-sur-Auron; 2fr. 75c. in the asylums).

The asylums in Belgium are in private hands, and it is difficult to obtain clear official statistics of their cost; but the patients in the insane colony at Lierneux cost in the year 1903 1fr. 50c. per head daily. The cost was about the same in Gheel. The charge in asylums varied in that year from 3fr. 50c. to 1fr. 92c. That is to say, the colonies were cheaper than the dearest asylum as 3 is to 7, and cheaper than the cheapest asylum as 150 is to 192.

I have no very recent statistics at my disposal of the cost of family care in Berlin, but several years ago, when the system was still new in its operation, the economy was remarkable; for whereas a patient in the district asylum, at Dalldorf, cost on an average £38 6s. per annum, a patient in family care only averaged £21 19s. The difference is nearer one-half than one-third. The disproportion is not so remarkable in Saxony. In Dr. Wickel's paper in this journal (September 21st, 1904) already referred to, it is pointed out that the maintenance charge in the Uchtspringet Asylum was 120 pfennige (about 14½d.) per diem, while the cost of the patients in family care varied from 80 to a little over 102 pfennige. The saving in maintenance might be calculated as one-fifth. More recent statistics, compiled since the numbers have grown, give the difference as one-fourth. The saving on the gross cost of the asylum patients, that is the cost including both maintenance and capital charges—more than 172 pfennige (about 1s. 9d.) a day—would be very great.

It is clear, then, that family care has been directly and indirectly an economy in the asylum budget. It would perhaps be reasonable to count on an immediate saving of one-fifth and an eventual saving of one-third on the maintenance account in the event of a fully organised system of family care being newly adopted in any country.

In connection with the economics of family care, there is a matter which should not be forgotten. It is notorious that the reclamation of the wilderness around Gheel, known as the Kampenland, and infamous as a barren desert since the days of Tacitus, is due to the labours of the insane. The natives themselves make this claim and point to their own present prosperity as the reward of their ancestors' charity to the afflicted, which has turned the desert into a garden. In all other insane colonies the like tale is told, though nowhere are there the same secular records, and perhaps in no other situation was the soil originally so bad. In Ireland there are many waste lands where the labour of the unsound of mind might be applied with advantage to the country generally and considerable profit to the small holders.

With reference to the best method of legalising family care in Ireland, there is little doubt that new legislation would be required, and it seems to the present writer that the best mode to adopt would be an extension of the existing law with reference to discharge on trial. At present patients can be, and often are, in the asylums of which I have had care, discharged on trial. The period of trial only lasts for one month, but the patient can be recaptured and brought back to the institution during the fortnight following the month's probation. At the end of the month he is supposed to be examined again and returned to the asylum or certified recovered. While such patient is absent on trial the law permits that his custodian be paid at a rate not exceeding the average maintenance rate in the asylum. By a very benevolent interpretation of this law as it exists, it might perhaps be made to cover such a system of family care as is used in Berlin, where the patient comes to the asylum once a month to be examined, but to work this would probably be impossible without a considerable amount of concession and make-believe on all hands. Besides, central control and inspection by the Commissioners would be indispensable if the system were to be extensively carried out. It might be held that this is implicitly contained in the present law, but it should be explicitly and strongly laid down and a thorough system of skilled supervision should be set forth lest in time neglect and scandal should arise. The mode on which family care can best be organised is undoubtedly that which is carried out around an asylum as a centre. It has been necessary to build a small infirmary at Gheel for the reception of cases when they first come to the colony, for the sick and for the occasionally excited. A similar building serves as a centre at Lierneux. In the colonies of the Department of the Seine (Dun and Ainay) a central infirmary has been found essential. In Berlin family care is organised in connection with the city asylums of Dalldorf and Herzberge, to which the patients return and from which the patients are inspected at the homes of their hosts. So it is generally on the Continent, and certainly in Germany. Probably the best organisation for the care of the insane existing in any country is that of the province of Saxony, admirably described by the special Commissioner of the *British Medical Journal* on Family Care, in an article in that periodical for March 11th, 1905, which should be in the hands of every one who is interested in family care. A generation ago this province built the model asylum of modern times—Alt-Scherbitz. More recently Uchtspringe was erected on the same general lines. From this centre, as we have seen, family care is extensively carried out. The latest asylum, Jerichow, from the plans of the accomplished Dr. Alt, is only constructed to contain at most 200 patients, from which centre an insane colony has been established in the neighbouring villages. We thus find developed in that country what has been the aspiration of the psychiatric world for the past few years—small, manageable, highly differentiated and organised asylums for certain classes of the insane, and for others the inestimable blessing of a life free from asylum restraints. The advantages to be derived from a continuance of skilled supervision by specialists who have studied and acquired a knowledge of any particular case are secured in family care conducted from an asylum. The boarding-out of patients comparatively near an asylum and still under inspection by the asylum physician, facilitates the transfer of patients to and from the institution and the homes of the hosts respectively, in a manner which contributes materially to the safety of the system and enables it to be applied to a large number of cases of circular and relapsing insanity which, under other conditions, one would hesitate to discharge.

The Scotch system, on the other hand, has many weak points. Patients may be and often are placed on the Lunacy Board Register as cases in private care without having been in an asylum, though it is fair to say that this class is diminishing. The system is, to a large degree, a system of parochial relief. Officers called Inspectors of the Poor have too much to do with the adoption of cases for private care, with the result that the numbers differ in different localities in the most wonderful way, according apparently to nothing except the zeal and ability of these gentlemen. Thus the Chairman of the Scotch Lunacy Commission told us at the Home Relief Congress in Edinburgh last year that Inverness-shire boarded out 44 per cent. of its registered poor lunatics (of whom, however, 22·6 per cent. were boarded with their own relations, and 21·4 per cent. with strangers); while Kincardineshire only boarded out altogether 6·7 per cent. Edinburgh at the same time boarded out with strangers 24·1 per cent.—a useful figure as showing what can be done even under what I esteem somewhat unfavourable conditions. Two deputy commissioners (medical men) visit cases in private care throughout the country, and all licences are granted or revoked by the Commissioners, who have the power of ordering the removal to an asylum or to another private dwelling of any patient who is not housed or treated properly. Otherwise, all supervision is carried out by the Parish Councils and their officers, medical and other. To adapt such a system to Ireland would involve, among other disadvantages, a profound and undesirable change in our lunacy law, which does not regard the destitute lunatic primarily as a pauper but primarily as a sick man. Those who know the Scotch system best, admit that decentralisation is carried too far, and that too much is left to the Parish Councils. The system there has grown up as it is, but could not be exported.

Finally, let us consider what may be the difficulties in the way of adopting this advance in Ireland. When I discussed this matter last year at the International Home Relief Congress at Edinburgh, I spoke of three obstacles in the way of initiating family care. Briefly speaking, these were official *vis inertiæ*; opposition from local bodies ignorant of the advantages of this system and more interested in maintaining the existing conditions with or without modification; and, finally, the difficulty of obtaining suitable locations among our wretchedly-housed people. The first two difficulties are incidental to the initiation of anything. They are to be got over by beginning. "Begin; the getting out of doors is the greatest part of the journey." With regard to the third, the standard of housing, as well as of life generally, is improving among the peasantry, and probably will improve further, and it is to be specially noted that in Belgium, France, and Germany, whenever family care has been introduced, the standard both of hygiene and comfort has risen amongst the hosts. Proverbially among these folk the reception of the insane brings luck, partly, perhaps, because the help which a working patient gives and the small profit that there is on his keep supply a little margin for comforts not otherwise obtainable; partly, also, no doubt, through the salutary action of the inspecting authorities. Looking further into the question in all its bearings, I am inclined to think that the fundamental difficulty which will be met with in the establishment of family care in Ireland is the indifference of the population to the interests of the insane, together with the absorption of the public intelligence in other affairs which renders men regardless of the administraton of the public charities of the country. While these conditions exist, it is hard to expect individual men to give up their time to the endeavour to introduce unpopular reforms, which are likely to miscarry through failure of the sympathetic public support which is essential for their success. And yet it is quite as true in this country as it was in France, when Dr. Christophe Féré, of Paris, an early and zealous advocate of family care, spoke, that success in this enterprise needs first of all that some one man should take the matter up and carry it through with as much energy as if he were managing his own private business.

Out-Patient Departments.

TOTTENHAM HOSPITAL

Dermatological Cases under the Care of G. Norman Meachen, M.D., M.R.C.P.

Case I.—*A Question of Diagnosis.*—A young man, æt. 25, came up with an eruption on the trunk, which, he stated, had been present for the last five months. It was irritable in character and he attributed its appearance to the wearing of a new flannel vest. No one else in his family or workplace was affected in a similar way. On examination, a papular eruption was seen covering the shoulders, back, and front, the buttocks, knees, and elbows. The hands and fingers were quite free. Several of the papules were covered with minute blood-crusts, but the most noticeable feature of the case was their tendency to assume a grouped arrangement. Moreover, a few of the lesions were vesicular, and here and there could be seen more or less recent scars which also possessed the same grouped appearance. No burrows were visible, and none of the lesions showed the characteristic "hæmorrhagic centre" such as one usually associates with pediculosis corporis. On these grounds, Dr. Meachen diagnosed the condition as one of *dermatitis herpetiformis of Dühring*. The essential elements of diagnosis of this disease, which is by no means a common one, are the symmetrical character of the eruption, its tendency to an herpetiform grouping, its intensely irritable nature, and, very often, its relapsing outbreaks. The scars present clearly pointed to older lesions of a similar nature. There was no history whatever, nor any clinical evidence of syphilis. Eczema, scabies, pediculosis, and prurigo were all negatived. The treatment consisted of a weak tar lotion, combined with the local application of a dilute sulphur and zinc oxide ointment.

Case II.—*Symmetrical Herpes of the Face.*—A girl, æt. 14, found on waking in the morning the day before she came to hospital that her chin and lips were covered with "small blisters." The night before she had felt some smarting in the face, but thought it was due to cold. When seen in the out-patient room, she presented a very striking appearance. The upper lip as well as the lower, including the central point of the chin, was covered with a typical eruption of herpes. Both sides were similarly affected, so that the central part of the mass was quite obscured by a herpetiform mass. The only exception to the almost absolute symmetry of the eruption was the left ala nasi, which was barely affected with vesicles at all. There was no enlargement of glands. The girl complained of cold shivers, and the temperature was 99·8. It was not a common event to see herpes zoster of any region of the body absolutely symmetrical, and though the two sides of the face are sometimes affected one after the other, it was seldom that both sides alike presented a similar acute efflorescence such as was present in this case. The resemblance of herpes to an exanthem was sometimes very striking, and in the acute stages of the disease the temperature was nearly always raised. A compound powder of boracic acid, zinc oxide, and starch was ordered for dusting on the affected parts, as well as a little boracic ointment. Quinine and magnesium sulphate were prescribed in a mixture, to be taken every four hours.

Case III.—*Eczema Squamosum simulating Tinea.*—A little boy was brought by his mother for what she called "ringworm" of the body, and for which she had religiously employed ink as a remedy. When seen, his shoulders and arms, the parts affected, presented a curious, stippled appearance, owing to the ink having missed certain portions of the patches. The lesions were discoid, averaging about one inch in diameter. One or two had not been painted with ink, in order that the mother should be able to demonstrate their character. These were pale fawn colour, their margins were not specially elevated, and there was no healing centre. No fungus was found on a superficial scraping. There was very little itching associated with the eruption. The total number of patches did not exceed half a dozen. It was not at all unusual for any circinate lesion, whether on the body or the scalp, to be described as ringworm by parents and friends. Even to the initiated, a little confusion sometimes arose in distinguishing between true tinea and other circular, discoid eruptions. The microscopic test was the only true one. The application of a little zinc oxide ointment, with which some ammoniated mercury was incorporated, caused the eruption to clear up in a fortnight. All irritating soap and clothing was advised to be avoided.

General Medical Council.

Dr. McAlister, President, in the Chair.

FIRST DAY.—Tuesday, Nov. 28th, 1905.

The following New Members were introduced to the President on appointment:—

Professor Robert Saundby, representing University of Birmingham (in the place of Dr. Windle), by Dr. Caton. Lieut.-Colonel F. G. Adye-Curran, M.D., Apothecaries' Hall, Ireland (in the place of Dr. Chas. Tichborne, deceased, and Dr. Atock), by Sir Christopher Nixon. Dr. William Tusting Cocking, University of Sheffield, by Sir John Williams. Professor Sir Thos. Richard Fraser, University of Edinburgh (in the place of Sir W. Turner, resigned), by Sir John Batty Tuke.

The President next informed the Council that Mr. Thomson and Dr. Pye-Smith would not be present at that day's meeting, as they were attending, at the President's request, the funeral of the late Sir John Scott Burdon-Sanderson, Bart., M.D.

The President then delivered his address. He said:

Gentlemen,—Since we last met certain changes of importance have taken place in the composition of the Council. Sir William Turner, our late President, has resigned his seat as representative of the University of Edinburgh. From the year 1873, the time of his first appointment by the Universities of Edinburgh and Aberdeen, his great powers have been placed at the service of the profession, and thirty volumes of our Minutes testify to the extent and variety of his contributions to medical administration. For a generation the Council has trusted his wisdom, his justice, and his zeal for its honour and efficiency. During the six years of his Presidency the warm personal esteem in which he was held within and without our membership grew deeper, as it was realised how greatly his qualities of mind and character enhanced the consideration accorded to the Council by the State and by the commonwealth of medicine. His high distinction as a man of science and as an educational statesman has been fittingly recognised by the Sovereign and by many learned bodies at home and abroad. But I have reason to believe that Principal Sir William Turner reckons it far from the least among his many honours that his colleagues on this Council, with whom he had so long been conversant, freely chose him to preside over them. In writing to accept his resignation, I felt that you would desire me to add an expression of the sense of manifold obligation and of grateful regard with which we bid him farewell.

Dr. Windle's appointment to the Presidency of Queen's College, Cork, has involved the severance of his connection with the University of Birmingham, and so with this Council, where he sat as its first representative. In him we have lost an able and clear-minded expert in education, general as well as professional, who did with his might whatever his hand found to do. The Education Committee, of which he was Chairman, will miss his firm grasp and wide knowledge of the questions that lie within its province.

Dr. Atock, who joined us last Session, was elected by the Apothecaries' Hall of Dublin only for the unexpired portion of the term of the late Dr. Charles Tichborne. He is succeeded as Governor of the Society and as a member of the Council by Dr. Adye-Curran, who holds the rank of Lieutenant-Colonel in the Army Medical Service, and who will doubtless be willing to afford us first-hand information regarding that important branch of our common professional life.

The University of Birmingham will be represented by Dr. Robert Saundby, one of its distinguished body of professors. His eminence as a physician and as an exponent of medical ethics and his familiarity with many forms of administrative work render him a valuable addition to our number.

From the University of Edinburgh we are glad to welcome Sir Thomas R. Fraser, Professor of Materia Medica and Clinical Medicine in that great school. As a recognised authority on Pharmacology and Therapeutics, he will be able to render the Council much assistance in regard to one of its statutory functions, the preparation and publication of the *British Pharmacopœia*. But his equally high reputation in other fields leads us confidently to reckon upon his aid, not in one only, but in all departments of the Council's activity.

From the new University of Sheffield, whose inauguration by their Majesties the King and Queen I attended as your representative last July, we receive an additional member in the person of Dr. Cocking, the Dean of the Faculty of Medicine in that University. In the constructive work which has accelerated the development of the Medical School of Sheffield into the present well-equipped Faculty, the Dean has borne an active part. In receiving him, we offer the right hand of fellowship to the youngest of our Universities, whose auspicious beginnings give promise of a vigorous and beneficent life.

By the University of Sheffield Act, 1905, which passed into law on August 4th, that University is "empowered to hold qualifying Examinations in Medicine, Surgery, and Midwifery, for the purpose of registration under the Medical Acts." Moreover, the Council of the University is entitled to choose one representative to be a member of the General Medical Council, "provided always that the fees for attendance and the travelling expenses of such member payable under Section 12 of the Medical Act, 1858, shall not be paid from the funds of the General Council or of the Branch Council for England until such time as, upon the representation of the General Council or of the Privy Council made in the manner set forth in Sections 10 and 19 of the Medical Act, 1886, and subject to the provisions therein contained, his Majesty may by Order in Council appoint."

The proviso just read was added to Clause 8 in its passage through the House of Commons, with the assent of the University authorities and of the promoters of the Bill. In accordance with your suggestions the Privy Council had previously been approached on the subject, and it was pointed out that the Clause in its original form appeared to ignore the power to provide for the representation of new Universities devolving on his Majesty in Council under the Medical Act, 1886. The objection was taken into consideration by the Government Departments concerned, and after conference with them and with certain members of Parliament, in which I had the indispensable assistance of Sir John Batty Tuke, the arrangement embodied in the proviso was ultimately adopted. Its effect is to conserve the above-mentioned power of his Majesty in Council, acting on the initiative of the General Medical Council, or in its default of the Privy Council, so far as any charge on our depleted funds is concerned. I venture to hope that this arrangement will be approved by the Council, as giving substantial effect to the wishes it expressed at our last meeting. In any case I must publicly tender my grateful acknowledgments to the various authorities and persons concerned for the spirit in which they received the representations I made on your behalf, and for the goodwill they exhibited in seeking and finding a practical solution of the question.

Another Bill affecting the Council has also passed into law, namely, that associated with the name of General Laurie and Sir John Batty Tuke, which was described by Sir William Turner in his Presidential Address of May, 1904 (Minutes, Vol. XLI., p. 5), and approved by you on May 31st, 1904 (Minutes, Vol. XLI. p. 89). The effect of the Medical Act (1886) Amendment Act, 1905, is to enable a part of a British Possession which possesses a local as well as a central Legislature to apply on its own behalf to his Majesty in Council for admission to the privileges of medical reciprocity with the United Kingdom. The Provinces of the Dominion of Canada, hitherto debarred by the terms of the Medical Act, 1886, from making such application individually, are now free to do so. The Canada Medical Act, 1902, which aims at unifying in certain important respects the medical administration of the Dominion, has so far proved inoperative; and the Federal Government is therefore unable to take up the question of reciprocity for the Dominion as a whole. The new Act removes the legislative deadlock. There is reason to hope that before long efforts will be made to obtain for great Provinces like Quebec and Ontario a position in relation to the British *Register* similar to that enjoyed by the States of the Australian Commonwealth.

A communication from the Lords of the Council conveys the interesting information that an application has been made to his Majesty on behalf of the Japanese Government, "requesting that steps may be taken so that Japan may be recognised as one of the countries to which the Medical Act of 1886 applies, thus enabling Japanese medical practitioners to practise medicine in the Straits Settlements as well as in other parts of the British Empire."

The decision that Part II. of the Medical Act, 1886, shall apply to a foreign country rests with his Majesty in Council. The foreign country must be one which in the opinion of his Majesty affords to the registered medical practitioners of the United Kingdom such privileges of practising therein as to his Majesty may seem just. According to my information, inquiries have already been instituted by the Privy Council, for the purpose of ascertaining the conditions under which British practitioners are permitted to practise within the Japanese Empire. Should the conditions prove to be satisfactory, and should the Order in Council accordingly be sanctioned, it will fall to the General Medical Council to consider what Medical Diplomas granted in Japan shall be recognised for registration in this country. Such Diplomas must furnish "a sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practice of Medicine, Surgery, and Midwifery," and the duly accredited holders may be registered in the Foreign List.

In view of the remarkable achievements of our ally in the domain of Medical science and practice, I do not doubt that the Council will await with sympathetic interest the result of the negotiations now in progress. I shall endeavour, at the proper time, to procure and to place before you the fullest information regarding the actual conditions affecting Medical Education and Examination in Japan.

I have already reported to the Council that Sir John Batty Tuke, during the last Session of Parliament, endeavoured to secure that the question of the unqualified practice of medicine and of dental surgery by certain limited companies should be inquired into by a Departmental Committee then sitting to consider the working of the Companies Acts. His efforts were unsuccessful, as it was officially affirmed that the question lay outside the scope of the Committee's reference. Undeterred by this refusal, he decided to introduce, in his own name, the two Bills on the subject which were drafted by Mr. Muir Mackenzie and submitted by direction of the Council to the Lord Chancellor. The purpose of the Bills may be briefly described thus: that any practice which, under the Medical and Dentists Acts, is unlawful when carried on by a person shall be declared unlawful when carried on by a limited company. The Bills were ordered by the House to be printed on June 26, and Sir John Batty Tuke sought to have them referred for consideration to the above-mentioned Committee; but he was unable to bring this about before the prorogation of the House in August. No small advantage was, however, gained by the publication of the Bills, and the Companies' Bills Committee will doubtless be prepared to consider them afresh, in the light of experience and of criticism, should a favourable opportunity occur for pressing them once more on the attention of the Government.

Steps have been taken by the British Dental Association to obtain in England a declaration of the law respecting Dental Companies similar to that which has already been procured in Ireland. In two instances the Attorney-General has, on the relation of the Association, granted his *fiat* for proceedings against registered companies which were held to be unlawful. In each case, however, the Company anticipated matters by dissolving, and the proceedings accordingly came to an end before they reached the stage of trial. I am informed that the Association may be expected to continue its public-spirited efforts in this direction. They concern the interest of the public no less than that of the Dental profession, and are worthy of our appreciative recognition.

Before I turn to the other business on the Programme let me say that, as your President, I was a guest at the magnificent ceremonies which were held last July in the metropolis of Scotland, to celebrate the four hundredth anniversary of the Royal College of Surgeons of Edinburgh. The proceedings, which extended over four days, testified to the world-wide fame of the Royal College, and to the affectionate esteem in which Sir Patrick Heron Watson, the *doyen* of this Council, and President of the College, is worthily held by his professional brethren.

In accordance with your instructions, the opinion of your legal advisers has been taken on the question whether degrees in dentistry are registrable as licences or primary qualifications; on the question whether a warning notice should be issued to practitioners with reference to the practice of advertising and canvassing for patients; on the question whether the Standing Orders prescribing the notice of inquiry addressed to accused practitioners should be amended, in cases where more than one charge is brought; and on questions arising out of the proposed revision of the Standing Orders relating to the Visitation and Inspection of Examinations. On all these subjects the Executive Committee will submit Reports for your consideration.

The Inspection of the Final Examination in Surgery conducted by the University of Edinburgh has been duly completed, and the Inspector's Report, together with the remarks of the University thereupon, has been forwarded to the members of the Council, and referred to the Examination Committee in the usual course. The present cycle of Visitations and Inspections is thus brought to an end. The Council will note with satisfaction that, though methods vary and requirements differ, there is no qualifying Examination in the United Kingdom which is reported to be "insufficient" to guarantee the possession of the knowledge and skill requisite for the efficient practice of Medicine, Surgery, and Midwifery. It is the statutory duty of the Council to maintain this standard of proficiency; and, to judge from the Reports before you, the means you have adopted for the fulfilment of that duty, in co-operation with the loyal efforts of the Licensing Bodies, have proved effective.

Important as is the maintenance of the standard of *examination* in the various branches of physic, the sufficiency of the course of *study* in each branch is not less important, and the Council, under Section XX. of the Medical Act, 1858, is responsible in an equal degree for its maintenance also. Sir John Williams, in May, gave us reasons for thinking that the accustomed routine of instruction in Practical Midwifery should be reconsidered, with a view to its possible improvement. On his motion a Committee of Inquiry was accordingly constituted. In order to ascertain the facts, I addressed a circular letter to the Schools connected with the several Licensing Bodies, asking on your behalf for the favour of answers to a number of queries drawn up by members of the Practical Midwifery Committee. The answers returned are highly instructive, and will afford matter for careful consideration by the Committee. They have been laboriously abstracted and classified by the Registrar, with the assistance of Mr. Cockington, and the Committee will in due course place the digest before the Council.

The question of making better provision for the teaching of operative surgery has received much attention from the members of the Anatomy Acts Committee, and some progress has been made during the vacation. The Committee will meet during the present Session to receive Reports as to the steps taken and contemplated, in pursuance of the power to act in the name of the Council which has been conferred upon it.

Mr. Secretary Lyttelton has been good enough to forward to the Council communications from a considerable number of Colonial Governments, in reply to the inquiries which, as Chairman of the Pharmacopœia Committee, I recently formulated respecting the inclusion in the next *Pharmacopœia* of the drugs and preparations sanctioned for local use in the *Indian and Colonial Addendum*, 1900. The documents have been referred to the Pharmacopœia Committee, to which they will be of great service during the preparation of the next issue. Copies of the new Pharmacopœias of the United States and of Spain have also been received. It is interesting to observe that in these the respective authorities have embodied the conclusions of the Conference on Potent Drugs held at Brussels in 1902, which were subsequently, with your approval, made the subject of an international agreement.

The Colonial Secretary has also transmitted for the information of the Council a series of important Ordinances and enactments referring to the practice of medicine, &c., in the Straits Settlements, Singapore, Ceylon, and the Orange River Colony. These are printed for convenience of reference in the Minutes of the Executive Committee. Members will doubtless observe, not without something akin to envy, that in these and other parts of the Empire the Legislature has had the wisdom to impose on unqualified practice legal restrictions, such as we have almost ceased to hope for at home.

To the Public Health Committee has been referred an important communication from the British Medical Association, requesting an expression of the Council's approval for a proposed Public Health Officers Bill. The Bill has a certain relation to the functions of the Council, inasmuch as it deals with the registrable qualifications of Medical Officers of Health, as well as with the conditions of their tenure. I have asked the Committee to consider its terms, in order that the Council may have the materials for forming a judgment as to the course that should be taken respecting it.

The other Standing Committees will also present Reports on matters referred to them. I have asked the Registrar to prepare a Report on the measures he has taken during the last five years for ensuring the correctness of the *Medical Registrar*. This Report will be printed and laid before you; it records a gratifying success in the difficult work with which he is charged.

The penal business at this Session is of some gravity, and may occupy a considerable proportion of the Council's time. The preliminary consideration it involves is the most anxious part of the President's duties; without the willing and efficient help of your Registrar and your Legal Advisers, and the experienced counsel of the Penal Cases Committee, the responsibility of decision would be onerous indeed. This aid and advice I have had in full measure, and I trust you will agree with me that each case brought before you, whatever may be its special features, is at least one that calls for inquiry by the Council as a whole.

Moved by Dr. Norman Moore, seconded by Mr. Tomes, and carried by acclamation: "That the President be thanked for his address and requested to let it be printed in the Minutes."

On motion from the Chair, it was then agreed: "That the Council do adjourn at 4 p.m. to enable certain Committees to meet for the completion of their Reports."

Moved by Sir P. Heron Watson, seconded by Dr. McVail, and agreed to: "That the table showing results of competition held in July, 1905, for Commissions in the Army Medical Service be received and entered on the Minutes."

Moved by Sir P. Heron Watson, seconded by Dr. McVail, and agreed to: "That the thanks of the Council be conveyed to the Director-General of the Army Medical Service for the Return which he had again furnished to the Council, with the request that these Returns may in the future continue to be furnished to the G.M.C."

Moved by Dr. Norman Moore, seconded by Mr. Morris, and agreed to: "That the Report by the Executive Committee on the Dental business transacted since the last session of the Council be received and entered on the Minutes."

This Report referred to the restoration of the following persons to the *Dentists' Register*, they having duly fulfilled the prescribed conditions: Emile H. Chapman, Horatio R. Miller, Charles W. Morrey, William Parker.

The Council received a Report from the President in regard to the following resolution as to primary dental qualifications passed on May 26th, 1905: "That the President be authorised to take the opinion of the Legal Advisers of the Council as to whether degrees granted in Dental Science and Dental Surgery by Universities in the United Kingdom are registrable as primary qualifications to practise dentistry."

An opinion by Mr. S. G. Lushington, given on June 5th, 1905, was then read. It was in favour of these degrees being registrable, and on the motion of Dr. Lindsay Steven, seconded by Sir Victor Horsley and agreed to, it was received and entered on the Minutes.

Moved by Mr. Tomes, seconded by Sir Victor Horsley, and agreed to: "That the Registrar be directed to accept for primary registration in the *Dentists' Register* certificates of degrees in dental science or dental surgery granted after examination by Universities in the United Kingdom."

Dr. Saundby was elected by the Council by ballot to fill the vacancy in the Penal Cases Committee caused by the retirement of Dr. Windle. Dr. Saundby, on being asked by the President whether he belonged to any body which brought complaints or instituted proceedings in medical cases before the Council, answered in the negative.

The Council then sat *in camera* to consider certain items in the progress of business, and subsequently adjourned.

SECOND DAY—Wednesday, Nov. 29th, 1905.

Dr. McAlister, President, in the Chair.

The Council proceeded to the consideration adjourned from May 24th, 1905, of the facts proved against William Patrick Kirwan, registered as of 21, Danbury Street, Islington, N., Lic. R.C.P. Edin., 1882, L.R.C.S. Edin., 1882, who had been summoned to appear before the Council to answer the following charges as formulated by the Council's solicitor:—(1) "That you have associated yourself with a Medical Aid Association, namely, a firm of chemists trading at various addresses as The Acme Medical Hall and Pharmacy, which Association has systematically, by means of printed circulars, cards, labels and notices, printed and painted, advertised your practice, name and qualifications, and thereby canvassed for patients for you."

(2) "That you have enabled certain persons in the employ of the Acme Medical Hall and Pharmacy to practise medicine and to treat patients as if qualified by law to do so."

On May 24th, 1905, after the conclusion of the deliberations of the Council on the case, the President addressed Mr. Kirwan as follows: "The Council have decided that the facts alleged against you have been proved to their satisfaction; they have adjourned their decision in your case till the next Session in November, when their judgment on the facts will be influenced by your conduct in the interval, more particularly in regard to canvassing, advertising and the employment of unqualified assistants, with respect to which matters they will require satisfactory assurances at the adjourned hearing."

Mr. Kirwan attended to answer the notice, and Dr. Bateman appeared on behalf of the Medical Defence Union, the complainants.

After the President had intimated that it would be inexpedient for any member who was not present at the previous hearing to take part in the judgment, Mr. Winterbotham read the notice and made a statement as to the present position of the case. Mr. Kirwan read a letter which he had written in regard to the action taken by him in the interval, and addressed the Council rather lamely on his own behalf. He also answered questions put through the Chair and was cross-examined by Dr. Bateman, who then called a Mr. Thomas William Tyrrel as a witness and examined him as to the accuracy of two statements made by him, which dealt with advice and medicine supply by an unqualified assistant in Mr. Kirwan's name.

The Council having deliberated *in camera*, on strangers and Mr. Kirwan being re-admitted the President addressed the defendant as follows: "Mr. Kirwan, the Council having further considered the facts proved against you, judges that you are guilty of infamous conduct in a professional respect and directs the Registrar to erase your name from the *Medical Register*."

The Council next considered the case of William Harding Crowther, registered as of 15, Bloomfield Road, Ealing, London, W., L.S.A., Lond., 1876, L.F.P. and S. Glasgow, 1880, who had been summoned to appear before the Council to answer the following charge, as formulated by the Council's solicitor:—

"That you have systematically sought to attract patients by means of a series of advertisements in the *People* newspaper of an Institution for Stricture, &c., at 8a, Guilford Street, Gray's Inn Road, of which you are the surgeon and which is carried on for your private gain."

Mr. Crowther did not appear in answer to his notice, nor was he represented by counsel or solicitor. Mr. Crowther, however, had written to the Council excusing his absence on the plea of illness.

Dr. Hugh Woods attended on behalf of the London and Counties Medical Protection Society, the complainants.

Mr. Winterbotham having read the notice, and satisfied the Council that the same had been duly sent to Mr. Crowther's address by registered post, Dr. Hugh Woods opened the case for the complainants. He read a declaration made by himself, and tendered himself as a witness and answered questions put to him through the Chair by members of the Council. He then tendered as a witness Mr. John Reardon, whom he questioned as to the accuracy of his (Mr. Reardon's) declaration. As no member of the Council desired to put any questions to the last witness, the solicitor of the Council read two letters which had been written by Mr. Crowther in which he (the defendant) gave bad health and domestic troubles as excuses for his non-appearance before the Council, besides stating that the advertisement had been stopped

The Council having deliberated *in camera*, the

President, after strangers had been re-admitted, announced the decision of the Council was that "they had found that the facts alleged against Mr. Crowther had been proved to their satisfaction, but they had adjourned the further consideration of the case until the next Session in order that Mr. Crowther might have an opportunity of appearing before the Council and giving an account of his conduct in the interval. Meanwhile, Mr. Crowther would be required to furnish at once a medical certificate in regard to his state of health."

The next case was that of Arthur Clarke Walker, registered as of 45, Mill Street, Liverpool, L.R.C.P. Edin., 1885, who had been summoned before the Council to answer the following charge, as formulated by the Council's solicitor: "That you seduced a girl, B— B—, who had come to you as a patient whom you had been treating professionally in your surgery, and who had on your invitation become an inmate of your house to help you in your work and to learn nursing of you."

Mr. Walker attended, but was not assisted by counsel or solicitor. In the absence of complainant, Mr. Winterbotham, after reading the notice to attend, read the following documents which had been furnished to the Council: three statutory declarations and two letters, and afterwards some letters which had been written by Mr. Walker in answer to the charge. Mr. Walker addressed the Council very feebly on his own behalf and answered questions put to him through and from the Chair, though he seemed in a very feeble and dazed condition. Standing Orders were suspended till the completion of his examination.

The Council then adjourned.

THIRD DAY.—Thursday, Nov. 30th, 1905.

Dr. McAlister, President, in the Chair.

The Council deliberated *in camera* on the case of Mr. Arthur Clarke Walker, and on strangers being re-admitted, the President announced the decision of the Council as follows: "The Council have found proved the facts alleged against Mr. Arthur Clarke Walker, that they have adjudged him to have been guilty of infamous conduct in a professional respect, and that they have directed the Registrar to erase from the *Medical Register* the name of Mr. Arthur Clarke Walker."

The Council next proceeded to the consideration of the case of Hamlet Lloyd Davies, registered as of 2, Crofton Street, Great Western Street, Rusholme, Manchester, M.B., Mast. Surg., 1874, Univ. Edin., who had been summoned to appear before the Council to answer the following charge as formulated by the Council's solicitor: "That you accepted and continued to hold the appointment of paid medical officer to the Rusholme and District Provident Dispensary, an Association which systematically practises canvassing for the purpose of procuring patients." Mr. Davies appeared in person, but without counsel or solicitor.

Dr. Bateman, in opening the case for the Medical Defence Union, made a long speech mentioning the steps which had been taken by the Medical Guild of Manchester to bring the practice of canvassing under the notice of the officers of the Manchester and Salford Provident Dispensary, of whom Mr. Davies was one in 1903, and giving an account of the founding of the Rusholme and District Provident Dispensary and the steps taken which induced the first medical officer to resign. A member of the Council here intimated through the President that, being a member of the Medical Guild of Manchester, he would take no further part in the proceedings, and on a question being raised concerning another Medical Association, Dr. Bateman explained that he was directed to bring the matter under the notice of the Council by the Medical Defence Union alone.

Dr. Bateman read statutory declarations from ten persons, all having reference to canvassing, and then called Dr. W. E. S. Scott and Mr. John Featherstone, both medical practitioners of Manchester, and questioned them as to the accuracy of statements made by them with reference to canvassing. No questions were asked these gentlemen by Mr. Davies.

Mr. Davies then addressed the Council and tendered himself as a witness. He professed absolute ignorance of the canvassing, and asserted he had told the Collector of the Dispensary that he would not keep the appointment if canvassing went on; he considered that the numbers increased in a Dispensary through the merits of the practitioner. He stated that he had resigned the appointment, but was obliged to give three months' notice.

Mr. Winterbotham read a letter which had been addressed to him as solicitor of the Council on behalf of the Rusholme and District Provident Dispensary, in which the President, the Secretary and the Treasurer of that institution denied any canvassing.

After the Council had deliberated *in camera*, and on strangers being re-admitted, the President addressed Mr. Davies as follows: "The Council have deliberated very carefully on your case and they have come to the conclusion that the facts alleged against you in the notice of inquiry have been proved to the satisfaction of the Council. The Council feel it their duty to express their sense of the gravity of the facts which have been proved against you, but in order to give you an opportunity seriously to reconsider your position in relation to the Rusholme and District Provident Dispensary, they have adjourned the further consideration of the charge until the next Session, when you will have to appear and satisfy the Council as to your conduct in the interval."

Moved by Dr. Bruce, and seconded by Mr. Jackson, and agreed to: "That the report from the Public Health Committee be received and entered on the Minutes."

Moved by Dr. Bruce, and seconded by Sir J. William Moore: "That the Council expresses its general approval of the provisions of the Public Health (Officers) Bill, 1905, with the exception of Clause 2 (1) which as at present drafted is too wide in its application." This motion was put and agreed to after an amendment by Sir Thomas Fraser, seconded by Dr. Saundby, had been withdrawn with the permission of the Council.

The Council then adjourned.

FOURTH DAY.—Friday, December 1, 1905.

Dr. McAlister, President, in the Chair.

The Council proceeded to the consideration of the Report of the Dental Committee on the charge against John Jones Atwood, Thomas Rose Smart, Walter Bennett, Algernon Frederick Green, Montague Alex. Levason, Daniel Shea and George Blount; all these seven persons are on the *Dentists' Register* as in practice before July, 1878. The charge against them was that they had signed the Memorandum and Articles of Association, and thereby become members of a Limited Dental Company, of which the only other persons who appear to be shareholders are G. Guy White and A. F. Sinclair Kennedy, who were on May 2nd, 1904, convicted and fined at the Marlborough Street Police Court, for infringement of the Dentists Act, 1878, that they had in various ways helped in carrying on the company, such as acting as manager, performing dental operations, handling the objectionable circulars of the company containing untrue statements. The said limited company was associated for the purpose of obtaining business with a society named the Benevolent Dental Society of Great Britain, which systematically and extensively issues advertisements of an objectionable character. The Committee had had before them statutory declarations from six persons with reference to circulars and advertisements; also various other documents, including letters from four of the defendants, and oral evidence from ten persons.

Mr. Atwood, with his solicitor, Mr. Green, Mr. Bennett and Mr. Shea attended in answer to their notice, and Mr. Turner appeared for the British Dental Association.

A motion by Dr. N. Moore, seconded by Sir Victor Horsley, for the Council to at once pronounce its judgment on the report was by consent withdrawn, and an amendment by Dr. M Vail, seconded by Mr. Brown, "That the parties be heard," put as a substantive motion, and carried. The four defendants therefore addressed the Council.

Mr. Atwood said that he had promised to do all in his power to sever his connection with the company as a shareholder; Mr. Green that he had acted only in his capacity as a servant; Mr. Shea and Mr. Bennett admitted the accuracy of the report. A letter from Mr. George Blount was read by Mr. Winterbotham. Mr. Turner then addressed the Council on the part of the complainants.

The Council then deliberated *in camera*, and on strangers being re-admitted, the President announced: "That in the cases of Atwood, Smart, Bennett, Levason, and Shea, the further consideration of the charge against them had been postponed until the next Session of the Council; in the case of Green and Blount, that on the facts found in the report of the Dental Committee, it had been proved that A. F. Green and G. Blount had been guilty of conduct, which is infamous or disgraceful in a professional respect and the Council directs the Registrar to erase from the *Dentists' Register* the name of Algernon Frederick Green and the name of George Blount."

Moved by Dr. Norman Moore, seconded by Mr. Morris, and agreed to, "That the report of the Executive Committee be received and entered on the Minutes." This report had reference to the Visitation and Inspections of Examinations.

Moved by Dr. M. Vail, seconded by Dr. Norman Moore, and agreed to, "That consideration of the proposed Standing Orders relating to the Visitation and Inspection of Qualifying Examinations be postponed to the May Session."

The Council then proceeded to the consideration, adjourned from November 29th, 1905, of the Report of the Executive Committee on the question of amending the notices of Inquiry in penal cases, so as to enable the Council in cases where more than one charge is brought to come to a decision on each charge separately. This report recommended the adoption of the Standing Order in a certain form, and contained an appendix relating to the notice to a registered practitioner to attend proceedings for removal of his name from the *Medical Register*.

Moved by Sir Victor Horsley, seconded by Dr. Norman Moore, and agreed to: "That this report be received and entered on the Minutes." Moved by Sir Victor Horsley, seconded by Sir T. Myles, and agreed to: "That the amendments to the Standing Orders suggested in the report be adopted."

Moved by Sir V. Horsley, seconded by Dr. Norman Moore, and agreed to: "That the report of the Executive Committee on the desirability of issuing a general warning notice to medical practitioners against the practices of canvassing and advertising be received and entered on the Minutes."

Moved by Sir V. Horsley, seconded by Sir J. Tuke, and agreed to: "That the recommendation in the report be adopted."

Moved by Sir Charles Nixon, seconded by Sir H. Beever, and agreed to: "That the report from the Executive Committee arising out of the correspondence with the Privy Council on the subject of the extension of Part II. of the Medical Act, 1886, to Japan be received and entered on the Minutes."

Moved by Dr. Norman Moore, seconded by Sir C. Nixon, and agreed to: "That the recommendation be adopted."

Moved by Sir William Thomson, seconded by Sir C. Nixon, and agreed to: "That the report from the Joint Finance and Executive Committees on the Institution of a Student's Registration fee be received and entered on the Minutes."

Moved by Sir C. Nixon, seconded by Sir W. Thomson, "That the recommendation of the Joint Committee, viz.:

"That the General Medical Council institute a fee of 5s. for registration in the *Medical and Dental Students' Registers* be adopted."

After some discussion the motion was lost. 16 against, 13 for, 4 did not vote, 1 absent.

Moved by Dr. MacKay, seconded by Dr. N. Moore, and agreed to: "That the report from the Education Committee be received and entered on the Minutes."

Moved by Dr. MacKay, seconded by Dr. N. Moore, "That the report be adopted."

The Council adjourned before the end of the debate on this motion.

FIFTH DAY.—Saturday, Dec. 2nd, 1905.

Dr. McAlister, President, in the Chair.

The President read his answer to a question by Dr. Norman Moore (of which notice had been given) with regard to the Sheffield University Act.

Dr. Lindsay Steven then continued his speech on the report of the Education Committee. Amongst other remarks, he said he considered the day of systematic lectures to be at an end. He proposed the previous question, and that the Council pass to the next item. Seconded by Mr. Brown, and carried.

Mr. Morris next proposed a motion on the desirability of transferring the primary subjects in the curriculum (chemistry, biology, &c.) to the preliminary stage. Seconded by Mr. Brown.

After the Council had given leave for this motion, Mr. Morris went on to say that the five years' curriculum had proved to be a deplorable failure; he thought scientific teaching had encroached on the student's time and had destroyed the teaching of anatomy. Science subjects, he considered, should be passed first. He remarked on the difficulty at present in procuring Prosectors for the R.C.S., in contradistinction to the old times, when the applications were numerous, and all the men good dissectors, which more recent men are not.

Mr. Brown said a few words in agreement with Mr. Morris, and after some remarks from Sir Thomas Fraser, Dr. Little, Sir Thomas Myles, and Dr. McVail—the last of whom was in favour of a six years' course, as he did not see where these subjects, especially biology, could be properly taught, excepting at a medical school—Dr. Pye Smith, seconded by Sir V. Horsley, proposed the closure, which was carried, when the motion was put and carried.

Moved by Sir P. Heron Watson, seconded by Mr. Young, and agreed to: "That the report by the Examination Committee on the answers from the Licensing bodies regarding Mr. Brown's motion as to returns from the Navy, Army, and India Boards, be received and entered on the Minutes. The answers referred to were mostly to the effect that no observations or comments were required."

Moved by Sir P. Heron Watson, seconded by Sir Thomas Myles, and agreed to: "That the report of the Examination Committee on the statement of Degrees Diplomas, and Licences of the candidates for Commissions in the Medical Staff of his Majesty's Army, relating to the Examinations held in July, 1905, be received and entered on the Minutes."

Moved by Dr. Norman Moore, seconded by Sir Thomas Myles, and agreed to: "That the report of the Examination Committee 'On the Inspection of the Final Examination (in Surgery) of the University of Edinburgh' be received and entered on the Minutes."

Moved by Sir P. Heron Watson, seconded by Dr. McVail, and carried: That the report be adopted.

Moved by Sir John Williams, and agreed to "That the interim report from the Students' Practical Midwifery Committee be received and entered on the Minutes."

The Interim Report was to the effect that the Committee felt it would be impossible to send in an adequate report, as the replies from some of the teaching bodies had only been sent in quite recently.

Moved by Dr. Norman Moore, seconded by Sir John Moore, and agreed to: "That the report of the

Pharmacopœia Committee be received and entered on the Minutes.

Sir Thomas Fraser was then appointed a member of the Pharmacopœia Committee in the place of Sir John Batty Tuke (resigned).

Moved by Sir **Hugh Beevor**, seconded by Dr. **Bruce**, and agreed to: "That the report from the Students' Registration Committee be received, entered on the Minutes, and approved."

Sir John Williams was then elected (as a nominee of the English Branch Council) a member of the Education Committee to fill the vacancy caused by the retirement of Dr. Windle.

It was then moved by the Chairman of the Business Committee, and agreed to: "That the President be authorised to direct a re-print of the Standing Orders, so as to embody any changes which have been adopted during the present Session."

Moved by Mr. **Morris**, seconded by Dr. **McVail**, and carried, "That it be referred to the Executive Committee, in consultation with the legal advisers of the Council, to consider and report on the following proposed amendment to the Standing Orders:—

'With the Notice of Enquiry, the Solicitor shall send an intimation that copies of any statutory declarations received in support of the charge will be supplied free of cost on the application of the accused person.'"

An application for registration by Mr. Robert Oates, M.B. Univ. Aberdeen, 1853, L.R.C.S.Edin., 1853, who had neglected to effect his registration until after June 30th, 1887 (under the Medical Act, 1886), though fully entitled to be registered under the Medical Act, 1858, was granted.

Moved by Dr. **Bruce**, and seconded by Sir J. **Moore**: "That an application from the University of Glasgow, for the recognition of its newly-instituted degree of B.Sc. in Public Health be considered." This was referred to the Executive Committee, together with a letter read by Dr. McCall Anderson.

Moved by Sir W, **Thomson**, and seconded by Sir **Victor Horsley**; "That a Committee be appointed to consider and report to the Council at its next Session, on the following matter: That a grave danger to the public health in Ireland has arisen from the present condition of the Irish Poor Law Medical Service, and that the Committee be instructed to report on the disabling circumstances under which registered medical practitioners are compelled to fulfil their public professional duties."

Sir W. **Thomson** made an admirable and picturesque speech, painting vividly the condition of the practitioners in this service, in the West, North-West and South-West of Ireland. He was followed by a few practical words from Sir V. **Horsley**. Sir J. **Moore** strayed rather into politics, and Sir **Thomas Myles** was vehement.

Several other members spoke, and finally the motion was dropped with the consent of the proposer and seconder.

A motion brought forward by Dr. **Finlay**, and seconded by Dr. **Norman Moore**, referring to a proposed amendment of the Standing Orders affecting the Penal Cases Committee, was discussed *in camera*.

Transactions of Societies.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD DECEMBER 1ST, 1905.

The President, Mr. L. A. **Bidwell**, F.R.C.S., in the Chair.

The Session was completed.

Dr. S. A. **Bontor** read a paper on

JAMAICA AS A HEALTH RESORT.

He remarked that in point of interest it would be hard to find a more suitable place, as the scenery would be difficult to surpass anywhere, while the native population, to one who does not know them, forms an additional source of interest. As to climate, this leaves little to be desired, for the Island is so mountainous that a very great variety can be obtained, while in many parts a very equable temperature can be enjoyed for a great part of the year.

Dr. Bontor's paper was followed by an instructive survey of some of the Continental health resorts by Dr. W. S. **Colman**, who said that the most important feature of these resorts was, that they were in beautiful surroundings; everything was done that is possible to make the treatment impressive, and so to influence the patient on the mental side as well as on the physical, while the comfort of the friends was also thought of by the satisfactory amusements provided both for them and the patients with them. At the same time the invalid was subjected to a regime which in the new surroundings he is willing to follow, because it is the fashion, and is therefore often much better controlled than could possibly be the case at home. In addition to these advantages the influence of the waters of the different spas, if one suitable to the particular case be chosen, was undoubtedly beneficial. Both the papers were illustrated by beautiful lantern slides and an interesting discussion followed.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, December 3rd, 1905.

PRECORDIAL FRIGOTHERAPY.

The favourable action exercised by the application of the ice bag over the precordial region when, in the course of some infectious malady, the heart shows signs of weakness, is well-known. M. Leduc, of Grenoble, has experienced considerable benefit from it in the treatment of fever where it acted as a powerful antithemic agent.

In a case of typhoid fever with delirium carphology agitation with fever at 103° and pulse 140, the ice bag was not slow to produce effect. Four hours after its application the pulse fell to 96 and became strong and regular. The temperature fell to 100° and the general symptoms improved. Other cases were submitted to similar treatment and with like beneficial results.

One curious fact was observed, which was that under the influence of the ice bag the action of antithemic drugs was more than doubled. In all these cases the antithemics which had but little effect when given alone acquired after the application of the ice an energy that was almost dangerous. For instance, M. Leduc in one case observed that four grains of pyramidon lowered the temperature from 104° to 96°.

M. Grimand observed a similar case. Before the application of ice, ten grains of pyramidon produced no effect, but after, two grains lowered the temperature and threw the patient into an abundant perspiration.

The antithemic activity of pyramidon is quadrupled by the employment of this method and that fact is worth bearing in mind.

In applying the ice bag care should be taken to interpose between it and the skin a piece of flannel and as the temperature falls the thickness of the flannel should be increased by one or more folds. In any case, the ice should not be entirely removed until after several days. The only inconvenience, remarks M. Mangel, is that the ice sometimes provokes pain in the axilla and down the arm. This trouble can be avoided, however, by placing a cushion over the axillary nerves, so as to prevent contact with the cold.

INJECTIONS OF AIR.

M. Cordier, of Lyons recommends the injection of air into the cellular tissue for relieving pain.

The only instruments necessary are the insuflator of a thermo-cautery and the needle of an hypodermic syringe. No antiseptic precautions for the skin are necessary, for the operation is simplicity itself and can be done in any region. The rubber tube of the insuflator is fixed and attached to the needle before inserting into the loco-dolenti and the quantity of air injected varies according to the region, the laxity of the tissues, the intensity and extent of the pain.

The idea is to distend the subcutaneous cellular tissue. For this purpose, the fingers of the left hand pinch the tube so as to prevent the passage of air, with the right hand the ball at the end is rapidly worked so as to fill the reservoir. Then the tube is let free and the air of the reservoir passes into the cellular tissue slowly and of its own accord. The air should not be pumped in. The little operation is painless. Generally the contents of the reservoir are sufficient, but when the pain covers a large region or the whole of a limb as in sciatica, for instance, two or three injections might be made at different points.

After the injection the place is gently massaged so as to displace the air. Patients experience a little numbness after the injection, but which quickly disappears, and relief from pain is almost immediate. Sometimes, however, several hours pass before the desired relief comes, but it seldom or never fails to come.

At first these injections were made to relieve neuralgia, but gradually they came to be the treatment for all kinds of pain and frequently with great success. Sciatica, intercostal neuralgia, lumbago, pain in side commonly called "stitch," or that felt in acute affections of the lungs, pleura, etc., are the affections amenable to the treatment. No accident has ever been observed.

Treatment of Mumps.

Mumps, as a rule, require but little treatment. However, parents are sometimes anxious and insist that something be done more than rest in bed and diet. In such cases the following treatment will satisfy all parties.

Instillation of a solution of menthol and oil (1-100) or gonrenol (10-100) into the nasal fassæ to ensure complete disinfection.

Gargles of—

Thymol, ½ drachm,
Menthol, 15 grs.,
Alcohol, 4 oz.

Ten or fifteen drops in half-a-glass of water to rinse the mouth.

If the fever exceeds 48 hours, warm baths may be given and a preparation of quinine given by the mouth.

Hydrochlorate of Euquinine, 12
Syrup of raspberry, 1 oz.,
Water, 2 ozs.

A tablespoonful three times a day for a child of 4 or 5 years of age.

Otalgia and orchitis constitute two frequent complications. For the former a plug of cotton wool steeped in laudanum is introduced into the ear and a piece of flannel coated with—

Guaiacol, ½ drachm,
Chloroform, 1 drachm.
Lanoline or Vaseline, ½ oz.

Applied to the parotid region and covered with cotton and oil silk.

For orchitis, poultices changed every 2 hours and when the pain subsides, replace them by the ointment:

Gonrenol, 1 drachm,
Ext. of hyoscyamine or of Belladonna, 10,
Vaseline, 1 oz.

Scopolamine.

By an error of the typographer the two preceding articles were headed "Scopoleine" instead of "Scopolamine." It is probable that the readers were able to make the correction for themselves.

Germany.

[from our own correspondent.]

Berlin, December 3rd, 1905.

The *Deutsch. Med. Zeitung*, No. 94, contains a notice of a case by M. Loeb of Basedow's disease running an abnormal course. The patient was a woman, æt. 46. Some of the symptoms of the disease were absent at first, and others were only moderately pronounced. The tachycardia was only moderate, 96 to 108, and without either subjective or objective palpitation. Exophthalmus, struma, and tremor were all absent, but on the other hand a number of symptoms which were usually of later onset were present—emaciation, diarrhœa, cough, hyperdrosis, and irregularity of menstruation. The exophthalmus only appeared after some months, the left eye being affected as well as Graefe's and Möbius's symptom. Recovery took place after some years. The cough that occurred in the course of the disease was attributed by Möbius to the goitre, but in this case there was no goitre in the early stage. As a rule, also, the exophthalmus affected both eyes at once, but it began occasionally in one eye as in the case under notice, but the second eye always became affected eventually.

The origin of the disease was attributed by the patient to mental excitement. Regarding heredity, he cites an instance in which a mother and three daughters suffered from the disease, two of them dying from it. Quinine, 1 grm. per day, continued for a long time, was used with good effect.

At the Medizinische Gesellschaft, Hr. Dührssen showed a woman with contracted pelvis for whose delivery he had sawed through the right os pubis subcutaneously, and had extracted a living child, the patient having been twice delivered by craniotomy on the living child. Sawing through the os pubis with subsequent drainage was very simple of performance, and it had the advantage of avoiding the objectionable feature of symphysiotomy, such as lacerating the corpus carcinosum of the cervix, with subsequent hæmorrhage, rupture of the urethra, with tearing of the anterior vaginal wall, and the damage to the walking power from want of union of the bony or cartilaginous parts. After severing of the bone extraction by turning becomes practicable. After delivery a couple of bandages of adhesive plaster were applied. In a fortnight the patient was able to get up and go about.

Hr. Edens spoke on the

Frequency of Tuberculosis of the Intestines in Berlin.

He had found such great differences in the statistics of Kiel and those of Berlin, that he had personally inquired into the matter as regarded the occurrence of the disease in the Bethanian Hospital. Amongst 491 autopsies, he had found 25 cases of primary intestinal tuberculosis. In 12 of these the diagnosis was quite certain; in the remainder it was only probable. He reckoned amongst the latter those cases in which there was a good deal of calcification of the mesenteric glands, in which other causes than tuberculosis could be excluded. The calcification was no proof of the age of the affection, as these glands calcified early. The justification for considering these cases as instances of intestinal tuberculosis was supported by the fact that out of 106 cases of pulmonary phthisis, he never found calcification of the glands without tubercle of the intestines being also present.

This relative frequency of primary tubercle of the intestines, in the face of the report of other Berlin authorities, was very striking, and required explanation more than did the difference between the statistics of different cities.

At the Hufeland Society, Hr. Ewald spoke on

Diseases of Digestion Associated with Hæmorrhage.

Hæmorrhages were of two kinds, the manifest and the occult. In case of the latter the diagnosis had to be made from chemical examination of the stools, care being taken to eliminate any blood that might have been taken in the food.

As causes of hæmorrhage, ulcer of the stomach took the first place, and the ulcer might be either recent or old. Hæmorrhages from old ulcers were preceded by prodromal symptoms, and it had a tendency to cease. Chronic hæmorrhages were in favour of chronic ulcers, the single copious hæmorrhage of recent ulcer. He mentioned a case of an otherwise healthy man, æt. 27, who died from hæmorrhage, and whose single symptom had been some feeling of oppression after food for five or six days. An old ulcer of the stomach was found with endarteritis.

Another cause was injury to mucous surfaces. These were of great importance from an accident insurance point of view. If an ulcer or a tumour followed immediately on an accident, a connection between the two must be assumed. The contrary was the case when a long interval came between the accident and the disease.

Other causes of hæmorrhage might be: Infective diseases, acute yellow atrophy of the liver, malaria, scurvy, &c. There were also vicarious hæmorrhages from suppression of the menses, rupture of vessels in thrombosis of the portal vein, in echinococcus, and, finally, post-operative bleedings.

Hæmorrhages in the higher parts of the intestinal canal and in the lower part of the rectum and anus occupied a second place. Such hæmorrhages took place from tuberculous and typhoid ulcers, and in embolism and thromboses of the portal region. Hæmorrhage from intestinal tumours, in enteritis, and cholera held a special place. In the rectum, hæmorrhages were limited to syphilitic affection. The signs of threatening hæmorrhage were rising temperature, a feeling of tension, and restlessness.

Discussing treatment, he mentioned a large number of remedies that had been used in cases of hæmorrhage from the stomach: Perchloride of iron, ext. sec. corn, hamamelis, hydrastis canadenses, stypticine, styptol, stagma (procured by autolysis of the spleen, but without any real result), and adrenaline. The last-named had left some writers quite in the lurch. Gelatine sometimes acted hæmostatically. The speaker recommended decoctions of gelatine with fruit juices. This was supposed to act through the high proportion of lime salts they contained. Ewald and Boas were very sceptical as to the advantages of solutions of calcium chloride. He had had undoubted results from washing out the stomach with cold water, until the water ran clear, with subsequent irrigation of the walls of the stomach with ice-water, with which the stomach was first filled, before the sound was allowed to penetrate deeply. Patients treated in this way had first a small dose of morphia and the fauces were treated with cocaine.

In threatened collapses, stimulants and saline infusion should be used. In desperate cases, operation might be tried, but the indications for it were difficult to determine. With failing cardiac activity thrombosis took place. He had only seen one fatal case. The results of operation were not brilliant; the mortality was 37 per cent. High-seated varices and hæmorrhoids were mentioned as causes of anæmia.

Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, December 3rd 1905.

Mitral Senosis with Recurrent Paralysis.

Frischauer related the history at the last meeting of the Gesellschaft der Aertze, of a female, æt. 30, a seamstress, who was received into hospital on August 7th, and died on October 30th. According to her own history, she had suffered from heart disease for the previous eight years. It seems to have commenced after a confinement which was in every respect normal. On her reception the apex beat was found in the fifth intercostal space fully two finger breadths outside the mammillary line. The cardiac dulness reached to the right of the sternum and upwards to the lower margin of the second rib. On auscultation both a systolic and diastolic murmur was present with accentuation of the second pulmonary sound. The laryngoscope revealed a slight paresis of the left vocal cord.

On September 4th, the patient was very hoarse and the left vocal cord quite paralysed. The Röntgen rays showed the flat space above the left ventricle to have two pulsating shadows, the lower, the auricle, and the upper, the pulmonary artery.

The clinical diagnosis was insufficiency and stenosis of the mitral valve with compression on the left recurrent nerve, probably from the enlargement of the left auricle.

The *post mortem* proved the diagnosis to be slightly at fault, as the auricle did not press directly on the recurrent nerve, but indirectly by pressing on the pulmonary artery, which again pressed the recurrent against the concave portion of the aorta, or, in other words the auricle jammed the nerve between the two arteries.

Störk demonstrated the preparation showing the vagus and recurrent to be lying in the normal topographical position, but the latter was found to be firmly fixed in the concave side of the aorta, and jammed by the pulmonary artery, which was again pressed on by the left pulmonary vein and auricle. At the point of compression the nerve was flat and of a greyish red colour.

Pal said he had a similar patient under observation at the present time, and, strange to say, the period of hoarseness commenced at the same time.

Reitter said he had searched all the literature on the subject for an equal, but in vain, as all were without a complete record of the *post mortem*, which was necessary for confirmation.

Grossmann gave the history of a case of recurrent paralysis combined with a febrile tachycardia.

Pal said he had had similar cases where tachycardia and brachycardia alternated.

Ortner added that in three cases he had no vagus symptoms were present. The *post mortem* clearly revealed the implication of the recurrent alone.

Thymus Degeneration.

Katholitzky showed a pathological preparation of the thymus gland, heart and lungs, taken from a patient æt. 46, who had suddenly died after being operated on for hernia. No hyperplasia or malignant condition of the thymus, neither was there any aplasia of the large vessels. Richter thought there was some connection between the exitus and the thymus condition that produced the cardiac failure, which, in the absence of a better term, might be called thymus death.

Operating Theatres.

GUY'S HOSPITAL.

Operation for Stricture of Ureter and Hydronephrosis.—**Mr. Arbuthnot Lane** operated upon a girl, æt. 14, who, about nine months before had fallen heavily on her left side, hurting her abdomen a great deal at the time and having pain which extended back into the loin. She did not vomit nor was there any history of her having passed blood in the urine. The discomfort ceased after two or three days. Some weeks after she began to complain of pain in the left loin and pain and tenderness in the left hypochondriac region and she had attacks simultaneously of renal colic when she passed blood in her urine in considerable quantities. The attacks were brought on by exercise and were sometimes very violent; at other times exercise merely produced hæmaturia with dragging and tenderness in the left loin and hypochondriac region. An X-ray photograph was taken which was supposed to show the presence of a stone of some size in the lower part of the kidney. On examination of the abdomen the right kidney felt quite normal, that on the left side was soft, large, and thick, but did not extend for more than half-an-inch below the level where the stone was supposed to be. The kidney was exposed by an incision in the loin; it was found to be hydronephrotic and firmly adherent to the parts around and fixed unusually high up in the abdomen. With great difficulty the kidney was detached from the tissues to which it was adherent. When the pelvis and ureter were defined, the former was found to be considerably dilated while the latter was small and shrunken in its lower part but dilated in the immediate vicinity of the pelvis of the kidney, whose dilatation it shared. At the point of junction of the two portions of the ureter a very tight constriction existed. Mr. Lane said he had determined to adopt on this occasion a procedure which had proved successful in similar cases in his hands. He incised the kidney along its outer aspect and managed to pass a solid bougie of small size through the stricture of the ureter, the end of the bougie being passed into the bladder. A rubber tube was then placed in the pelvis of the kidney for the purpose of draining its cavity; this was subsequently made to communicate with a bottle placed under the bed. During the three weeks which the patient was kept in bed urotropine was freely administered, and the left kidney was drained through the loin. At the end of this time the drainage tube was removed but the bougie was still left in position. While the child occupied the recumbent posture urine escaped from the wound in the loin, but when the sedentry or erect posture was assumed the urine secreted from the left kidney passed into the bladder by the side of the bougie, showing that the process of dilatation of the stricture was proceeding satisfactorily. Mr. Lane did not propose to remove the bougie for some considerable time. At this stage it was possible to change the bougie without difficulty. He was strongly of opinion that in all these cases of hydronephrosis, whether resulting from injury or excessive mobility of the kidney a proceeding such as he had carried out in this case should be employed rather than that a considerable mass of useful kidney tissue should be removed. The process of dilatation will end, he pointed out, when the stricture of the ureter has been sufficiently dilated, but the risk of the too early removal of the bougie would not be run since the patient suffers no inconvenience from its presence. This operation, he remarked, had already been described by him several years ago in the MEDICAL PRESS AND CIRCULAR.

OPERATION FOR RELIEF OF THE RESULTS OF CHRONIC CONSTIPATION.—The same surgeon operated on a woman, æt. 32, who looked at least ten years older. During the whole of her life she had suffered severely from chronic constipation; at first she experienced little trouble from it; the infrequency with which the bowel emptied itself caused her no inconvenience; as time went on she began to suffer from biliousness, general malaise, attacks of discomfort or even severe pain in the lower part of the abdomen, and dragging pain in both loins, especially in the right, an utter feeling of incapacity to do any work, loss of flesh, staining of her skin, especially under the eyelids, her temples, her neck, axillæ, the nipple and its areola, the umbilicus and loins; her feet and hands were always cold and she noticed that her perspiration and breath were very offensive, her gums were inflamed, her tongue coated and her skin dry and covered with minute epidermic scales; as far as her capacity to get about was concerned, her day ended at 1 or 2 o'clock, after which time she felt only inclined to lie on her back; at the commencement of her menstrual period she had great pain and tenderness on the left side of the pelvis; she suffered a great deal from flatulence and frequently belched up large quantities of gas from her stomach. Examination of the abdomen showed that the cæcum and the middle of transverse colon were placed in the true pelvis, the ascending colon and cæcum and descending limb of the transverse colon were firmly connected by adhesions, it being impossible to separate these structures in any position of the body, the sigmoid flexure was shortened and fixed to the back of the iliac fossa, and pressure on the true pelvis in the immediate vicinity of the brim on the left side caused the patient a sensation of pain, which was distinctly ovarian and which the patient said simulated that which she suffered during her periods. There was some tenderness of the liver, both kidneys were more mobile than they should have been, the right especially so. The abdomen was opened in the middle line, the cæcum, the ascending, transverse and descending portions of the colon were removed as far as the sigmoid; the distal extremity was closed. The left ovary and the extremity of the Fallopian tube were found to be involved in the adhesions that had developed about the sigmoid in the process of its fixation to the iliac fossa; the ovary was already undergoing cystic change. This condition of matting of the left ovary and frequently of the Fallopian tube which takes place in the process of the anchoring of the sigmoid loop posteriorly is, Mr. Lane remarked, very commonly present, and in some cases the cystic degeneration is very advanced; when it is advanced the ovary becomes freed from the adhesions in which it was originally fused and forms for itself a serous covering between the mesentery of the sigmoid and the most superficial layer of the acquired adhesions connecting the sigmoid itself to the iliac fossa, those adhesions which originally existed between the meso-sigmoid and the iliac fossa having been destroyed or absorbed by the enlarging left ovary. It is obvious, he pointed out, that at a later stage the enlarging ovary would destroy the remaining adhesions and any evidence of the apparent causal relationship of the adhesions to the cystic degeneration of this organ would be lost. He was strongly of opinion that a large number of cases of cystic degeneration of the left ovary result directly from chronic constipation in the manner here described. The rectum was then displaced to the right side of the pelvis and pinned there by a number of silk sutures. The end of the ilium was next closed and a lateral anastomosis was effected between it and the rectum in this situation. The stomach was then examined and found to be dilated and hypertrophied and its pylorus hung up by a shortening of the lesser omentum, which had clearly resulted from an endeavour to oppose the drag on this organ, which was exerted by the boarded transverse colon in any position other than the supine. The distension of the stomach had also brought about an adhesion of its posterior wall to the peritoneum in the vicinity. Mr. Lane also examined the gall bladder. There were, however, no evidences of inflammation of this organ in this particular case. In a considerable proportion of these cases of advanced constipation Mr. Lane finds evidences of an infective inflammation of the gall bladder either as thickening of its walls or more commonly as definite adhesions, while in other cases gall stones are present in varying quantities. He is of opinion that inflammation of the gall bladder, such as he had described or the presence of gall stones is a direct consequence of chronic constipation, and he cannot recall a case showing such conditions in which there were not present also most definite evidence of the habitual accumulation of fœcal matter in the large bowel and the associated stagnation of the contents of the small intestine.

BY the will of the late Mrs. Emma Poncia, of Edgbaston, the Birmingham General Hospital and the Queen's Hospital at Birmingham will each benefit to the extent of £10,000.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 6, 1905.

THE GENERAL MEDICAL COUNCIL.

The opening address of the President of the General Medical Council is always an event of interest and sometimes of importance in the world of medicine. Vested with autocratic powers, that virtually irresponsible body may and does wield matters fraught with vast potentialities for the welfare or otherwise of members of the medical profession. In the gentleman who has recently assumed the office of president, Dr. Donald McAlister, we are pleased to recognise a brilliant and broad-minded worker, and already it is comforting to believe that certain straws on the surface of the Council's deliberations show that at last the current is setting in the direction of reform. The excuse of the Council when pressed to this, that or the other step with regard to the real protection of the medical profession or with regard to their non-representative constitution has been to point to their statutory authority with a monotonous cry of *non possumus*. But the mere fact of inadequacy does not prevent the Council from seeking to obtain further powers from the Legislature when their own pet and peculiar functions are concerned. In proof, we turn to Dr. McAlister's own statement of what has been effected even in the barren and tottering Parliament of 1905. The University of Sheffield Act of that date confers the power of sending a new representative to the General Medical Council, but the Council can apparently refuse him payment. In this instance a compromise was effected, against the wish of Sir John Batty Tuke, who sought to save the depleted funds of the Council from further expenditure. Then, again, an amendment of the Medical Act was carried in the present year with a view to establishing unity and reciprocity so far as Canadian Medical qualifications are concerned. If the Medical Acts can be amended in foreign matters, why cannot they be altered as regards quack medicines and irregular practice—things that come home to general practitioners in the United Kingdom every day of their lives? Why should the General Medical Council be so earnest in extending an invitation to Japan to practise in our Eastern dominions, while they do not raise a finger to check the overwhelming torrent of competition by bone-setters and pirate practitioners of all sorts and conditions? An Imperial policy in these affairs spells neglect and ruin for the rank and file of medical men at home. Besides, the General Medical Council was primarily created with the view of protecting the British public and the British qualified medical practitioner. It is to be hoped that the first step in the direction of reform will come from the Council itself by an unselfish effort to make the governing body of the medical profession representative. As things go, every freshly-created University swells the preponderance of vested interests in the Council as against those of the main body of the medical profession. What clear and convincing reason can the Council bring forward to account for their inaction in the matter of increasing the number of direct representatives? Possibly, under the guidance of Dr. McAlister, we shall see this vital point handled fairly and squarely. We are glad to see that one member of the Council, at any rate, not only has the courage of his convictions, but loses no opportunity of giving them practical effect. We allude to Sir John Batty Tuke, who, during the last session of Parliament, did his best to secure that the question of the unqualified practice of medicine and of dental surgery should be inquired into by the departmental committee then sitting to inquire into the working of the Companies Acts. His efforts were unsuccessful, and he then introduced, in his own name, two Bills to declare that any practice which was unlawful on the part of an individual should also be unlawful if carried on under the Medical or Dentists, Acts. Both Bills have been elbowed out for the time being. The British Dental Association, however, has gained the sanction of the Attorney-General to prosecute companies practising dentistry. If that movement succeed, it should be open to the British Medical Association to prosecute companies practising medicine. Were our General Medical Council constituted and guided on common-sense, democratic lines it would, long ere this, have put a stop to abuses in both the directions indicated. But the Council combines business inaptitude with conservative class narrowness, for it actually has no reasonable machinery for furnishing the revenue necessary to its administration. It is curious, indeed, how a liberal and progressive profession like that of medicine can for a moment endure the despotism of so mediæval a governing body. Much the same thing prevails in the government of the various qualifying Corporations of the United Kingdom. Some day medical men may turn from internecine quarrels and jealousies and set their house in order, commencing with their colleges and their General Medical Council. That desirable consummation being attained, it will be possible to turn an effectual front against the ceaseless competition of unqualified practice. Will not the General Medical Council be wise in time, and meet reform half-way ?

TREATMENT OF ADVANCED TUBERCULOSIS.

In practical affairs, especially at the present day, there is eminently a need for balance—the maintenance of a sense of proportion. The tendency in a busy world is for this, that, or the other aspect of a subject to be presented to men, and for it to fill their minds to the exclusion of all else. To-morrow it is something new. Much good has undoubtedly been done by those agencies which have brought before the country the need for more ample and systematic arrangements being made for consumptives, but there is no less danger that enthusiasts may bring the cause into discredit. Now, although there are great and obvious advantages in sanatoriums for certain and suitable cases, when practical considerations come to be studied, it is at once evident that the provision of sanatoriums sufficient to accommodate every consumptive in the country for the whole necessary period of treatment would—even if otherwise desirable—be negatived by the enormous cost that would be entailed. Then the advocates of sanatorium treatment are primarily concerned in catching their patients early in the disease, and it is not pretended that benefit of such a substantial nature as to make direct appeal to the public interest is likely to accrue to sufferers from advanced tuberculosis. The treatment of these patients, then, has to be thought out on other lines. Again, in their cases, the question of infection arises. Since the great "awakening" of 1901, and the active pushing of anti-consumption propaganda that issued from it, necessary though it undeniably was that people should understand the dangers of tubercular infection, there has arisen in the public mind an inordinate and disproportioned dread of consumptives, on the ground of their infectiveness. It should hardly be necessary to say that a consumption patient, who is reasonably careful and who is nursed by people of average intelligence, presents a public danger so small as to be practically negligible. Such cases can be cared for at home or in hospitals or infirmaries without compunction, if proper precautions be observed. Moreover, as in tuberculosis of the lungs, arrest not infrequently takes place in unpromising cases, it becomes a matter for serious consideration whether the lives of patients unfitted for sanatoriums may not be prolonged, and even saved, and their comfort certainly enhanced by measures directed to combat the disease itself, or, rather, to enable the patient to combat the disease. There are plenty of patients who are sufficiently well to get about, and even do a certain amount of work, who, from a the stage of their disease or their private circumstances, are unable to avail themselves of a course of sanatorium treatment, and there are too many patients who are, or should be, confined to bed, whose lives can be greatly brightened by the knowledge that their cases are not considered hopeless, and that active therapeutic measures directed to their recovery are being taken. I such patients are fairly well-off, it is not usually difficult to arrange for their treatment by open-air methods in their own homes, if these are situated in the country or open suburban districts ; suitable devices for admitting air without admitting draughts into the rooms can be planned with the exercise of a little ingenuity, and shelters or tents can be set up in the garden. But with poor patients any course of the kind is out of the question, and at present the position of the poor consumptive is a sad one indeed. To medical men who have this problem placed before them, and they are many, we would recommend the perusal of a paper of great practical interest by Dr. Knopf, of New York, published in the *Medical Record*, of November 18th. In it they will find a great deal of sensible advice born of experience in dealing with the poor of the City, and what strikes us as being of special value is the description it gives of various forms of apparatus which afford the poor consumptive the benefit of living in the open air, although he occupies the same room as others of the family and is confined to bed. Of these the simplest, most effective, and—as it is not protected by patent—the cheapest, is a device of his own invention. The bed in which the patient lies may be placed either alongside or at right-angles to the window, and the apparatus, which is practically a half tent, is fitted by galvanised iron bars into the window-frame, and extended over the upper half of the bed. The patient is thus isolated completely from the rest of the family, and by opening the sash is actually in the open air. All the points connected with this window-tent have been carefully thought out. For instance, in order that the patient may not feel unduly sequestered, a celluloid window is inserted in the side of the tent that faces the centre of the room ; an extension of the tent through the frame of the window protects him from rain ; and a roller-shade is arranged to keep out light and heat, when these are too strong. These window tents are said to be acceptable to patients who will not sleep with the window open, and they are certainly useful when the other occupants of the room object to draughts if the sash is left down in the ordinary way. Of course, a patient occupying such a tent must be warmly covered, and in the case of the very poor, Dr. Knopf suggests placing newspapers between the blankets, a plan that has been found to work well. The head and neck can be encased in a knitted helmet, and a woollen sweater or jacket worn on the upper part of the body. Other methods of conveying fresh air into the living rooms are described—the next best to the one mentioned being by means of a *porte d'air*, invented by Dr. Kellog. This consists of a large flexible tube like a fire escape, one end of which can be fitted into the window, and the other fixed tent-wise over the head of the bed. The important lesson taught by these inventions is that if fresh air is of such vital importance in tuberculosis, it can be obtained at a very cheap rate in patients' homes, and this being so, it becomes a duty to attempt to provide it for the poor and poor sufferers from advanced disease. How far a little care and ingenuity can overcome the difficulties in the way are well illustrated in the original paper.

Notes on Current Topics.

Massage by the Blind.

IT is well known that the sense of touch is usually excessively developed in subjects deprived of the sense of sight, and that, in consequence, blind people are well fitted for the performance of actions for whose guidance fine tactual perception is sufficient. It is with a clear grasp of this fact that the Japanese have, we believe, for many generations employed the blind in the practice of massage. With proper instruction they are said to make most skilful masseurs, while their delicacy of touch renders their ministrations more pleasing than those of persons of more robust sensibility. The exercise is healthful for themselves, both physically and mentally, the pursuit of an active profession giving them an interest in life they are not likely otherwise to obtain. In some Continental countries the Japanese example has been followed, though as yet we have not heard of any blind masseurs in England. In St. Petersburg a regular course of two years' instruction in anatomy and physiology is given to blind pupils to fit them for this occupation, and much of the massage of the Russian capital is in the hands of those thus trained. In Brussels, Leipzic, Brünn, in Austria, and other places there are schools for the training of the blind in massage work, and in America, in Philadelphia, there is a school of the same sort working with considerable success.

Poor-law Commission.

As announced by the Prime Minister at the end of last session, a Royal Commission on the working of the Poor-law has been appointed, and, as we stated at the time, this Commission will be of great importance to the profession on account of the many medical matters that will fall within its purview. The *personnel* which has lately been made public will, we fancy, be generally regarded as satisfactory on account of the large proportion of independent students of social questions that it embraces, but we confess that considering the nature of their duties, we believe that the Commission should have contained more than one medical man. Dr. Downes, as medical adviser to the Local Government Board for Poor-law purposes, has long been known as an energetic and able official, but it is no disparagement to him to say that it would have been more satisfactory to the profession if his name had been joined with that of some medical man independent of Government and departmental interests. The terms of reference to the Commission are of the widest, so wide that it is matter for wonder as to where the Commission will eventually find themselves landed. It will be regrettable in the extreme if their labours are spun out like those of the late Vaccination Commission and the present Sewage Disposal Commission over a period of many years, during which no reform in, or legislation on, the subjects they are investigating can be undertaken. The Irish Poor-law Medical Service is a case in point. The changes that are needed in that department are of pressing importance, and it is much to be hoped that they will not now be shelved for ten years on the ground that nothing can be done till the Commission has reported. It is disappointing, too, that the administration of the Vaccination Acts will not fall within the scope of the inquiry; their handling by the guardians at present is notoriously unsatisfactory.

Medical Candidates for Parliament.

IN view of the General Election which is presaged by so many portents in the political atmosphere, it is interesting to notice that a larger number of medical men are coming forward as candidates for Parliament than has been the case before. This is a sign of hopeful augury, for it is patent to everybody in the profession that many of the grievances under which medicine suffers and many of the disabilities of the Public Health Service are due to inadequate representation of the profession in the House of Commons. It is impossible, or next to impossible, for a practising doctor to sit in the House, and as rich and leisured men are not common in our ranks, one cannot hope ever to see a proportion of medical members of Parliament at all commensurate with that of the lawyers. But it is of the utmost importance that a strong and cohesive body of militant medical members should sit in the House to watch and criticise public health questions, and therefore one welcomes the appearance of fresh candidates. In all there are nineteen in the field at the moment, eight of whom are members of the present House. Of the latter only one is a supporter of the present Government, but nearly all the new candidates are either Conservatives or Liberal Unionists. Perhaps the most picturesque figures of the would-be members is Sir Conan Doyle, who is to contest Hawick Burghs in the Liberal Unionist interest, and it may be feared that there will not be wanting those who will grudge the inroads that his parliamentary duties will make into his literary work. The two groups of Scotch Universities are both to be contested by medical men, namely, Sir J. Batty

Tuke, M.P., and Professor W. R. Smith, whilst Sir Michael Foster will stand again for the London University. The three Irish Nationalist M.P.'s who are medical men are once more coming forward again for their respective constituencies, and Dr. H. O'Neill is going to fight Belfast as a Conservative. Surgeon-General Evatt, who has been so prominently before the medical profession in Ireland, is Liberal candidate for the Fareham Division of Hampshire.

Direct Manipulation of the Heart.

Direct manipulation of the heart in cases of chloroform-poisoning, where pulse and respiration have both failed, is a measure of resuscitation which every surgeon should bear in mind. In the unfortunate cases where it is required, no means giving any hope of success should be neglected, and there is now on record more than one case where such manipulation has proved of avail when every other means appeared useless. A case recently published by Drs. Smith and Daglish, of Stockton-on-Tees (*a*), is peculiarly instructive. The patient had been four minutes in chloroform anæsthesia, when respiration and pulse ceased, and the apex-beat could not be felt. Artificial respiration produced no respiratory movements, and the case seemed hopeless. The surgeon, without longer delay, cut into the abdomen, and inserting his hand, easily grasped the heart, in whose muscle there was only the feeblest tremor. A few seconds' kneading the heart caused a slight contraction, and inside of a minute the heart was beating regularly, and respiration was soon restored. Recovery occurred without interruption. An interesting point in the case, though of secondary importance, is that no infection of the peritoneum occurred, although the hand introduced had a moment previously been in the rectum, and only very perfunctory cleansing had taken place. This fact is illustrative of the extreme resistancy to infection possessed by the normal peritoneum.

Health of Paris.

From the Middle Ages till the present time Paris has been regarded as the hub of the intellectual and artistic life of Europe, and though other cities from time to time contend that they have equal claims to be considered as the chief centre of light and leading, such a position has not been universally accorded to any of them. In municipal affairs, too, Paris is, in theory, far better organised and mapped out than any other city of the same magnitude and complexity, and it has always been assumed that it was therefore better administered. An unofficial report on the health of Paris has just been supplied to the French Academy of Medicine by Dr. Lowenthal, a scientist whose opinion is bound to carry weight. In this report he strongly criticises the hygienic record of the capital, and compares it, to its great disadvantage, with that of other European cities. The two important criteria of general sanitary conditions in large towns are the typhoid and tuberculosis death-rates, and Dr. Lowenthal shows that the typhoid death-rate is eight times and the tuberculosis death-rate is three times that of Berlin. The efficiency of vaccination administration in Germany, and the inefficiency of that in Paris, is shown by the small-pox death-rate for the latter city being three hundred and fifty times that of the former. Dr. Lowenthal assails also the municipal reports, which he shows gravely underrate the seriousness of the position. Englishmen may be surprised, but they will certainly be pleased to find that London and the work of the London County Council are held up as examples of what should be in sanitary matters, and the municipal authorities are advised to follow in our steps. The housing policy pursued by the Council is especially commended.

Diagnosis.

In a recent address, Dr. John B. Deaver, of Philadelphia, criticised severely the methods of diagnosis in which, according to him, the medical student of to-day is exclusively instructed. "The tendency to base a diagnosis solely, or almost entirely, on laboratory findings was widespread and becoming more constantly prevalent. The reason that this fondness for laboratory diagnosis was so widespread was, he thought, because the students of medicine were taught laboratory methods to an undue extent. The constant cry in all medical colleges at the present day was for funds to build and equip laboratories. The students were forced to spend hours at a time in the laboratories studying the products of disease or the causes of disease, while the time formerly allotted to the study of disease itself was reduced to a minimum or was altogether expunged from the roster. Instead of drilling into the minds of students the eternal principles of surgery, the faculty sent them into the laboratory, to the end that they might become adepts in the art of blood counting, or may be rendered capable of distinguishing between consanguineous tribes of micro-organisms. In his judgment this was a fatal mistake." (*a*) It is perhaps hardly true that in this country things have as yet come to the stage deplored by Dr. Deaver, but the tendency is entirely in that direction. The scientific instruction of medical students has now, as was inevitable, fallen entirely into the hands of men who know little of the requirements of medical practice, and consequently are unable to take a comprehensive view of the necessities of medical education. It can hardly, however, ever be sufficiently emphasised that while the sciences are the necessary basis for the structure of medical education, they are not the structure itself. They are merely the foundation on which clinical experience is to raise its edifice. The tendency of much medical education of the

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(*a*) *British Medical Journal*, November, 18th, 1905.

(*a*) *American Medicine*, October 14th, 1905.

present day to attempt to substitute instruction in laboratory methods for bedside experience is one that threatens to be disastrous to the future of the profession.

Country Doctors and Country Parsons.

A correspondence has been gong on in the *Western Morning News* about the grievances of country doctors and country patients, and a suggestion is made by a clergyman who contributes to the discussion that a certain amount of medical knowledge by the clergy would be of use not only to their flocks, but to the doctor. The correspondent himself, armed with a clinical thermometer, visits all patients before the doctor is sent for, and if he finds the case a trivial one, he apprises the doctor to that effect, and if it appears to be serious he endorses the summons sent. The work of a country doctor with his many poor patients, his few rich ones, and his long journeys, is a far from enviable one, and when, in addition to the natural drawbacks of his calling, he finds himself treated with want of consideration by his distant patients he would be more than human if he did not resent it. No doubt the suggestion made, namely, the endorsement of all summonses by an educated and responsible person, such as the parson, is an excellent one—provided the parson confines his attention to the medical aspect of the case within that limit—and no doctor would be other than grateful for his help and kindness under such circumstances. But the possession of medical knowledge by non-medical people has so often proved a thorn in the doctors' sides, that they would naturally be chary of approving unconditionally an arrangement which brought a third party between them and their patients.

Hippocratic Oath for Nurses.

There is undoubtedly a considerable laxity on the part of many nurses with regard to the preservation of professional confidences—a condition of things which is often annoying both to doctors and patients, and which argues a defect in their hospital training which should be made good. It is natural that a nurse who is confined to one house and one family circle for her daily round of duty should find her conversation turn to the events which happen within them for the topics of her conversation, but, at the same time, it ought to be remembered that the temptation is one to be resisted. Great prejudice is entertained by many persons against the nursing profession in general owing to the indiscretion of one or two individual members of it in repeating stories of dreadful things that have happened in the houses of former patients, or in relating domestic details that should have been locked up in their own bosoms. We think that the tone of the nursing profession with regard to the sacredness of professional confidences should be raised, till it comes to be regarded as bad form for nurses to gossip about the circumstances that come before them in the exercise of their calling. A new and interesting departure has been made in the lately-reorganised New York City Training School for Nurses. The period of training was recently extended to embrace a three-years' course of study, and last month the first batch of nurses "graduated" after the completion of this term. As part of the ceremony at which the diplomas were granted, each nurse had to come forward and take the Hippocratic oath to preserve inviolate the secrets of the sick-room. We commend the idea to the ladies of the nursing world on this side of the Atlantic.

Antivivisectionist Business Methods.

Some recent proceedings in Chancery are of interest as showing the haphazard way in which antivivisectionists are apt to conduct their affairs. The looseness of their mental processes is writ large in their bitterly aggressive and unscrupulous attacks upon members of a humane profession. No better instance of the sheer malignant rhetoric dear to this curious sect could be quoted than that which led to the payment of heavy damages by Mr. Stephen Coleridge to the University College professor whom he had slandered. Yet, one was hardly prepared for the news that the British Union for the Abolition of Vivisection has no officer legally qualified to accept a legacy on behalf of that illustrious body. The late Treasurer was Judge J. F. Norris, who also acted as executor to the late Miss Frances Power Cobbe. A legacy from the last-mentioned to the Union has raised the question whether the present treasurer has any legal status on the ground that the meeting at which he was elected was improperly convened. Meanwhile the Vice-Chancellor has taken the money into his own charge. The sympathies of a world that, in its heart, is slipshod and unbusinesslike, will doubtless go forth to the British Union, etc., in its present dilemma.

Contagiousness of Typhoid Fever.

It is only a few years since it was regarded as an elementary fact in regard to public health that typhoid fever infection was in most cases carried in the water supply. The occurrence of several disastrous outbreaks of the disease, such as that at Maidstone, and recently at Lincoln, traceable to this cause, naturally emphasised it to the exclusion of others. More careful observation, however, and noting of instances, makes it necessary to return more or less to the old notion of personal and direct infection. To mention a simple example in the experience of all, cases of typhoid fever are constantly occurring among nurses, house physicians, and others employed in waiting on those sick with the disease, but, when one considers the channels by which the bacillus leaves the body, it is difficult to see how this occurs. The fæces are, of course, loaded with living typhoid organisms, and in a large proportion of cases the urine is in a similar condition. It is impossible, therefore, for a nurse, or, indeed, for a house physician, to avoid contaminating the hands at times, and any carelessness in cleansing them may result in self-infection. The danger rising from the presence of flies is also not to be overlooked, as by their aid bacteria from fæces, urine, or soiled linen, may be deposited on food or drink. It behoves all, therefore, who are entrusted with the care of the sick to take every precaution as to the isolation of a typhoid patient as long as typhoid bacilli are present either in the fæces or urine.

Radium and Hydrophobia.

There is no disease with which we are brought face to face where we find ourselves so helpless as with hydrophobia. It is true that in the case of no disease has prophylactic treatment been more fully justified—unacquainted as we are with the specific organism—but once the symptoms have developed, the most we can aim at is some mitigation of the sufferings of a painful and terrible death. If some recent investigations, however, be confirmed, it is possible that in the case of hydrophobia, radium will work its greatest therapeutic triumph. It appears that in experimenting with radium, Tizzoni and Bougiovanni discovered that its presence destroyed the virulence of the fixed virus of rabies *in vitro*. Following the hint thus given, they applied radium to the eye of rabbits inoculated with the disease. In early cases, where no symptoms had developed, the radium seemed to inhibit the incubation of the disease, and the animal escaped. In some later cases, even after the development of active symptoms, a cure was wrought. The nervous disturbances disappeared, the fever went down, and the animal recovered. These facts seem so unaccountable that we wait eagerly for a confirmation which will bring hope to the prognosis of a disease hitherto regarded as necessarily fatal.

The Sanitary Congress on Drinking-Water Supplies.

The Royal Sanitary Institute occupies a position of considerable importance as a populariser of the science of hygiene. Its annual meetings in various parts of the United Kingdom bring home to the people a number of things that intimately concern the national welfare. The Hastings meeting was held last week, and reached the usual average of interest and success. The main subject of discussion was water-filtration, introduced by the Medical Officer of the Borough, Mr. Scarlyn Wilson. That gentleman mentioned the interesting fact that last year not a single case of enteric fever occurred in their town population of 67,000 people. He pointed out the necessity of trusting to purity of source rather than to methods of filtration. A good deal was said by other speakers as to pressure filters, and many other aspects of water-supply were touched upon. The newspaper reports, however, make no reference to the greatest advance in modern methods, namely, heat sterilisation applied to water in bulk. Sooner or later this method will almost certainly be enforced in the case of all drinking water drawn from a source where it has been exposed to contamination, as, for instance, from such rivers as the Thames, the Severn, and the Trent, all of which supply an enormous number of persons, and are grossly contaminated with sewage.

The General Medical Council and the Irish Poor-Law Service.

A most important discussion took place at the General Medical Council on Saturday last, when Sir William Thomson proposed the following resolution :—" That a committee be appointed to consider and report to the Council at its next session on the following matter : That a grave danger to the public health in Ireland has arisen from the present condition of the Irish Poor-law Medical Service, and that the committee be instructed to report on the disabling circumstances under which registered medical practitioners are compelled to fulfil their public professional duties " ; and in the course of his speech gave a detailed account of the present condition of the Service. His resolution was seconded in a sympathetic speech by Sir Victor Horsley, and was spoken to by several members of the Council, all of whom were agreed as to the crying want of reform in the Service. Sir Patrick Heron Watson even went so far as to say that the speech of the mover of the motion was one of the most horrible disclosures he had ever heard. " But," he added, " if things are so bad, why will not these men move elsewhere ? The Colonies are large enough." This may sound an unfeeling remark, but at the same time it hits at the root of the whole matter. Readers of The Medical Press and Circular do not require to be told that the picture drawn by Sir William Thomson is neither distorted nor exaggerated. This being so, Sir Patrick may well ask his question, though perhaps if it had been couched in a slightly different form, and if he asked instead " Why are there candidates for every vacancy in the Service ? " it would have been better. The fate of Sir William Thomson's motion was postponement, in order that the opinion of the law agent might be taken as to whether it was in the power of the Council to appoint a committee for such a purpose. We do not like to appear unduly pessimistic, but we fear that, even if the Council is empowered to appoint such a committee and if it bestows all the time and labour in its power upon the condition of the Poor-law Service, that Service will benefit not a whit. There is but one way in which to effect such reform, and that is the way outlined by Sir Patrick Heron Watson, and plainly stated by Sir John Moore—stop the supply of the candidates and keep it stopped. But, before such a course is possible, we must have unity in the ranks of the medical profession, and we must have an influential and representative medical society in

Ireland. We fear that recent events do not encourage one to hope for the speedy presence of either.

Proposed Membership of the Edinburgh College of Surgeons.

On November 27th, a deputation from the Association of Medical Diplomates of Scotland was received by the President and Council of the Royal College of Surgeons of Edinburgh. It was signed by between 700 and 800 Licentiates and Fellows, and prayed the College authorities to consider the possibility of creating the qualification of membership, either by substitution for or addition to the existing Licentiateship and Fellowship. The deputation consisted of the President of the Diplomates' Association (Dr. Farrer), the Treasurer (Dr. Bell), and the Secretary (Dr. David Walsh). The petition, handsomely embossed on vellum and bound in red morocco, was then formally handed to the President of the College, Mr. C. W. MacGillivray. As a number of the Licentiates are in practice in various parts of the Kingdom where the majority of neighbouring practitioners hold the membership of the English College, there can be little doubt that the creation of an Edinburgh membership would add greatly to the popularity of the ancient body in question.

Tropical Diseases and London Post-Graduates.

The facilities for post-graduate study in London have been steadily increasing of late years, so that the requirements of almost all workers, general or special, could be supplied. The addition of the Seamen's Hospital to the list, however, is of great value both as a complement and a supplement to the existing organisation. The connection of the institution named with the Royal Albert Dock has rendered it a valuable and unique field for the training of the students of the London School of Tropical Medicine. It possesses 250 beds, and therefore offers an ample supply of clinical material. It is clear that with the addition of a teaching staff and suitable laboratories, lecture rooms, and some good scheme for out-patients, there should be a future as a post-graduate school for what has long been recognised as a most useful and well-conducted medical charity.

PERSONAL.

The King has been graciously pleased to make Sir George Anderson Critchett, Surgeon-Oculist to his Majesty, Commander of the Grand Cross of the Victorian Order.

His Majesty the King has graciously signified his intention to be present at the Quartercentenary of the University of Aberdeen in 1906, and to open the new Marischal College Buildings.

The King has been pleased by warrants under the Royal Sign Manual, bearing date November 17th, 1905, to appoint the Right Hon. Mr. Justice Kenny, Sir Rowland Blennerhassett, Bart., Sir John William Moore, M.D., His Honour Judge Shaw, and John Lentaigne, Esq., F.R.C.S.I., L.R.C.P.I., to be visitors of the Queen's College, Cork.

Dr. James D. Williamson, of Belfast and of Helen's Bay, has been appointed a Justice of the Peace for County Down.

Dr. Arthur Downs is a member of the Royal Commission appointed last week to inquire into the working of the Poor-law.

Dr. Alexander Robertson, of Glasgow, was last week entertained by the Scottish Branch of the Medico-psychological Society on the completion of fifty years work in psychological medicine.

Dr. J. M. Graham last week delivered his Presidential Address to the Royal Medical Society of Edinburgh.

It is stated that during her lifetime, Mrs. John Elder gave away about £200,000 to Glasgow charities. Her will directs £50,000 to be devoted to the endowment of the Elder Cottage Hospital. The deceased lady enjoyed the unique honour of holding the LL.D. degree, *causâ honoris*, of the University of Glasgow.

We learn that Lord Currie has sent a donation of £50 to the North-Eastern Hospital for Children towards the amount required by December 31st to enable the Committee to avoid a deficit on the year.

On Sunday, November 26th, the Bishop of London attended Divine Service at the Mount Vernon Hospital for Consumption and addressed the patients.

On December 1st, H.R.H. The Duchess of Albany visited the Royal Infirmary, Glasgow, and inspected the scheme of reconstruction to be carried out as a memorial to Queen Victoria.

Dr. Joseph Kellett Smith has bequeathed £1,000 to the Stanley Hospital, Liverpool.

The late Mr. Adolf Hesse, of Nottingham, has bequeathed nearly £39,000 to the Nottingham General Hospital.

The inquiry into the application of the British Medical Association to disallow certain payments made by Mr. John Troutbeck, the coroner for Westminster and South-West London, to Dr. Freyberger for *post-mortem* examinations and giving evidence at inquests, was concluded on Monday. Mr. Cockerton, Local Government Board Auditor, has reserved his decision.

Mrs. Bedford Fenwick, founder of the International Council of Nurses, has been elected an Hon. Member of the German Nurses' Association, in recognition of the work she has accomplished in furthering international unity between trained nurses all over the world.

Special Correspondence.

[from our own correspondents.]

SCOTLAND.

Social Problems in the Highlands.—Dr. [illegible] L. Grant, whose name was so prominently before the medical profession and public some years ago in connection with the Ballachulish quarries dispute, addressed a crowded meeting in Oban on November 11th on social questions in the Highlands. Dealing with the question of sanitation, he admitted much that had been said and written lately as to the backward sanitary conditions in which many of the people in the Highlands and Islands yet live. The proper feeding of the school children was also a matter urgently requiring attention. For these and other sanitary reforms, money should be given in the form of exchequer grants, where the county was already rated and taxed to the utmost. The social problem in the Highlands, like the social problem in London or anywhere else, is indissolubly wrapped up with the political issues of the day, and Dr. Grant's address was therefore *ex necessitate* of a political nature. National land tenure and a crofters union were two fundamental points in the vista of social and economic reform; while he advocated afforestation on an extensive scale, and welcomed the establishment of local industries. Improved transport and communication was also required to improve the condition of the Highlands. Dr. Grant has at least one advantage over many who discuss the land problem in the Highlands—viz., a medical man's intimate knowledge of the true conditions of life there, and the sympathetic insight born of personal intercourse with the population.

BERI-BERI IN GLASGOW.

The danger of introduction of tropical diseases to this country through the media of vessels and their crews received another illustration on Saturday last, when two Chinamen, both firemen on board the steamer "Peleus," which arrived in the Clyde from the Far East, *via* Marseilles, were discovered to be suffering from beri-beri, and were removed to Belvidere Fever Hospital, Glasgow. All precautions are being taken by the sanitary authorities.

BELFAST.

Curious Case at Bangor, co. Down.—An inquiry was held last week by the Coroner for County Down, Dr. R. C. Parke, into the circumstances attending the death of a woman and child. The woman was attended in her confinement by a "handy woman," who, it was alleged, was under the influence of alcohol. Severe hæmorrhage came on, and the woman sent the husband for a doctor. Drs. Gorman and Aird were brought, and found the patient in a state of collapse, with a wound or tear several inches long in the uterus. The child was dead. The mother was removed to the Cottage Hospital, where she died three days after from "blood poisoning and puerperal fever." The verdict of the jury was that the patient died from blood poisoning produced in some way which they could not discover, and they added a rider to the effect that all similar cases should be attended by a certified nurse, unless a doctor were in charge of the confinement.

Action Against a Doctor.—The case of Tughan *v.* Darnell, which resulted in a verdict for Dr. Darnell when tried before Mr. Justice Wright and a special jury in Belfast, is to come on again. The plaintiff applied for a new trial on the ground of misdirection to the jury, but this application was refused by the King's Bench Division last June. The Court of Appeal, however, has reversed that decision, and a new trial has been allowed. The circumstances of the case have been given in these columns several times, and need not now be repeated. Dr. Darnell has the sincere sympathy of all his medical brethren in this vexatious prolongation of the matter.

Belfast Maternity Hospital and the Midwives Board.—After the most dogged perseverance and many months of fighting, and reams of apparently fruitless correspondence, the hospital authorities have induced this ridiculous Board to come at last to a sensible conclusion and to admit to certification all nurses trained in the hospital before April 1st, last, as provided by the Act of Parliament. This places these nurses on the same footing as those of the Rotunda and Coombe Hospitals in Dublin. The Board has for months refused to do this, but the Medical Press took the matter up, and Lord Londonderry, the Lord President of the Council, also took it in hand. All through the various phases of the fight two members of the Board have been good friends to the Hospital, Sir William Sinclair and Dr. Ward Cousins, and to them and the Marquis of Londonderry the Hospital authorities have passed a hearty vote of thanks.

Health of Belfast.—At the monthly meeting of the Belfast Corporation held last week the Medical Officer of Health reported that in the previous four weeks the medical men of the city had notified 234 cases of zymotic disease—viz., 100 cases of scarlatina, 45 typhoid, 41 erysipelas, 22 simple continued fever, 19 diphtheria, 6 membranous croup, and 1 puerperal fever. There were 27 deaths from zymotic diseases, and 88 from phthisis.

Rumoured Changes in Belfast.—The resignation of the Medical Officer of Health for the city has often been expected during the last few years, and various rumours have been current at different times concerning it, and the likelihood that a job would be perpetrated by the Corporation. We have it on excellent authority that a medical member of that body is at present actively canvassing for the post, and is about to resign his seat in the Corporation so as to have the necessary six months' "retirement" before he is elected to Dr. Whitaker's post. It is most important that the public, and specially the medical men of the city, should keep an eye on this matter, for considering the highly unsatisfactory state of affairs in the Public Health Department it is essential that we should have a really strong man in this post—one with special training and qualifications, and not a general practitioner who has attended a few lectures and taken some diploma in sanitary science or public health.

Correspondence.

SIR F. TREVES' ADDRESS AT EDINBURGH.

To the Editor of the Medical Press and Circular.

Sir,—It is but natural that Sir F. Treves' address to the laity on a medical subject should call forth such a letter as that of Sir Wm. Broadbent. Nevertheless, it must be admitted that the surgeon has proved himself to be a physician as well, which, indeed, all surgeons ought to be. I will not venture to criticise Sir William Broadbent's letter, although there is abundant opportunity to do so. I desire rather to point out that Sir F. Treves, in his graphic description of the warfare of diseases, is only following the great teachers, who at wide intervals of time venture to stray from the beaten track. Hippocrates studied disease by observation of facts, and having come to the conclusion that medicine was a corollary to dietetics, proclaimed the chief aim of the physician to be to find a diet suitable to the sick. His practice was most successful. Sydenham, who deserves to rank with Hippocrates in the history of medicine, was also a close student of Nature, ventured to oppose the practice which prevailed in his day, and brought what has been called "Commonsense," to bear upon treatment. He tried to assist, and not to oppose Nature. He was afraid of being misrepresented, and in concluding his chapter on Pestilential Fever, he thus writes:—

"In the last place, I will add this short note, lest perchance anyone should wrest my opinion by a sinister interpretation, or at least not thoroughly understand it, viz.: that in the preceding discourse, I often use the word *Nature*, and attribute various effects to her, as if I would represent under this title, some one thing, subsisting of itself, and spread everywhere through the whole machine of the world, which, being endued with reason, governs all bodies, such a thing, as some of the Philosophers seemed to think, was the soul of the world. But, as I do not affect novelty of things, so neither of words, and therefore I use in these pages the ancient word indeed, but in a sense, unless I am deceived, both taken, and not only understood, but also used by the best men, for as often as I mention Nature, I mean a certain complex of natural causes, which are governed by the best counsel in performing their operations, and accomplishing their effects, though they are without reason, and destitute of all skill, viz.: The Supreme Deity, by whose power all things are produced, hath so disposed all things by his infinite wisdom that they betake themselves to their appointed functions doing nothing that is vain, but that which is fitted and best for the whole fabric of things, and their own private nature and so are moved like engines, not by their own skill, but by that of the Artificer."

Since the germ theory was promulgated, we may have advanced in our knowledge of Nature's way of working, and know much that was unknown to Sydenham; but who will venture to say that the physician of to-day is more successful in treatment than Sydenham was with his vegetarian diet for the sick, and his insistence on the necessity for fresh air in the treatment of all diseases. What we now specially require to study is the primary cause of disease, and, if Pythagoras was right, when he said that a man ought to be ashamed of being ill, except from accident, or climatic influences, we must look for the primary cause of every disease in man's departure from following Nature in his way of living, for which civilisation is accountable.

The moral of Sir F. Treves' address, as well as of those words of Sydenham, is that we should study Nature more than we do in our search for the cause, as well as in the treatment of disease, and if, by returning, as it were, to Nature, we could prevent or even mitigate the severity of our modern diseases, is it not our duty, as members of the medical profession, to give the laity a lead?

I am, Sir, yours truly,
John Haddon., M.D.
Denholm, Hawick, Scotland, Dec. 3rd, 1905.

AN INTERESTING CASE OF NUTMEG POISONING.

To the Editor of The Medical Press and Circular.

Sir,—Mrs. M., a woman of about 30, came to me about 9 o'clock p.m. on November 15th, in a great state of terror. She stated that at about 5 o'clock she took the whole of a large nutmeg grated in half a quartern of gin, because it was five weeks from her last period. She stated that she had also taken a half nutmeg in gin the previous week. She was very excited, could not keep still, and complained of burning dryness in mouth. She had spasms of larynx and lower jaw, difficulty in breathing, giddiness, and singing in ears. The lips were deeply cyanosed, the face flushed, and the nails dark, pulse very small and rapid, the heart was beating rapidly and jerkily, no murmurs, no nausea. She stated that she felt queer, but not ill on the occasion when she took the half nutmeg.

As it was so long since she had taken the nutmeg (four hours) I did not give an emetic, but sent her to bed with hot bottles, and gave hot milk to drink and a strong mixture of magnes. sulph. and carb. with ammon. carb. to be taken every half-hour till bowels were freely cleared. Next morning she was all right. She stated that she did not feel ill till nearly 8 o'clock, but as she had some fried fish for tea about 6 o'clock, the fulness of the stomach may have delayed the absorption. It is noteworthy that there were no symptoms of narcotic poisoning.

I had not previously heard of nutmeg being used as an abortifacient.

As the case is so unusual I thought you might find room for it in your valuable journal. I may add that it did not produce the effect desired.

I am, Sir, yours truly,
James Hamilton, M.D. Q.U.I.
60, Sydney Street, Chelsea, S.W.

Obituary.

DR. J. F. STEWART, G.M.S. (Murdered in Nigeria).

We regret to learn that a telegram has been received at the Colonial Office, from the Acting High Commissioner of Southern Nigeria, reporting that Dr. J. F. Stewart had been attacked and killed by natives at Atrara, a place between Owerri and Bend, in Southern Nigeria, on Nov. 16th. It appears that Dr. Stewart who had gone out on his bicycle into a wild region at Atrara, lost his way, and was fired at, and took refuge in a native compound, where, however, he was cut down. Dr. Stewart, who was the son of Dr. John Stewart, of Carlisle Circus, Belfast, had been home recently on leave, and only returned to the West Coast of Africa last month. He served in the South African campaign as a civil surgeon, for which he held the Queen's medal, with three clasps. On his return from the war he had the offer of several Colonial appointments, and decided to accept one on the West Coast of Africa. During his term there he took part in a number of punitive expeditions, and, altogether, for the last six years he had seen much fighting. Dr. John Stewart's many friends will sympathise with him in his sad loss.

CAPTAIN J. V. ROCHE, R.A.M.C.

Intelligence has been received by cable from India of the death of Captain James Valentine Roche, Royal Army Medical Corps, at Lucknow, India, as the result of an accident on the 25th ult. Captain Roche was the son of Dr. John Roche, Workhouse Medical Officer, Fermoy, with whom the sincerest sympathy is felt in his great bereavement. The sad and premature demise of this gallant young officer is deeply regretted as he was a general favourite, and gave promise of a distinguished career.

DR. JAMES RANKEN.

We regret to announce the death of Dr. James Ranken, the doyen of the medical profession in Kilmarnock, at an advanced age. He had been in practice for about forty-nine years, and was one of the best-known men in the town. The death of his wife a few months ago considerably affected his health, but he was in harness practically up till the last. Belonging to an old school of medical men, he had great faith in old-fashioned methods, but it was admitted by his fellow-practitioners that he practised these with great skill and success.

THOMAS RUSSELL CRUISE, L.A.H.Dub.

The death of Mr. Thomas Russell Cruise, who was one of the churchwardens of St. Mary's, Willesden, took place last week at his residence, Church End, where he carried on a practice in succession to the late Dr. Roberts.

JOHN CROFT, F.R.C.S.Eng.

By the death of Mr. John Croft on November 21st, at the ripe age of 82 years, the London medical world has been deprived of a well-known figure. He entered St. Thomas's Hospital so long ago as 1850, and in 1854 took the diploma of M.R.C.S.Eng. and L.S.A. In 1860, after serving for some years in the "Dreadnought," he returned to St. Thomas's as demonstrator of anatomy and surgical registrar, and in 1859 took the F.R.C.S.Eng. In 1863, he was appointed resident assistant surgeon to the hospital and surgeon to the Surrey Dispensary. In 1871, he became full assistant surgeon to St. Thomas's and surgeon six months later. He also acted as lecturer on clinical surgery and consulting surgeon. Among many important professional offices he filled that of Vice-President of the Royal College of Surgeons. His contributions to practical surgery were numerous, and some of his contributions to contemporary literature were of more than passing interest. He leaves behind him a widow, his second wife, but no children.

Royal Colleges of Physicians and Surgeons of Ireland.

The following candidates have passed the Examination for the Conjoint Diploma in Public Health:—Hugh William Bailie, L.R.C.P. and S. Edin., Alice Mary Barry, L.R.C.P. and S.I., William Cremin, L.R.C.P. and S.I., Ragunath Vithal Khedkar, L.R.C.P. and S. Edin., William Francis Brenan Loughnan, L.R.C.P. and S.I., Connor Joseph O'Loughlin Maguire, M.D., R.U.I., Francis Joseph Moore, L.R.C.P.I., and S.I., John James O'Sullivan, L.R.C.P.I., L.A.H.

Laboratory Notes.

MOSELEYS COCOA AND FOOD.

Moseleys Cocoa (Foods, Limited, Stockport.) is stated to be prepared from the finest pure cocoa powder and Moseleys Food. There are several points which should commend this preparation to lovers of cocoa. In the first place as it contains Moseleys Food, the use of milk can be dispensed with, although having tasted it both with and without milk we prefer its addition. What perhaps will be even more appreciated is what has been aptly called the bouquet, which is, so far as our experience of cocoas goes, unique, and is likely to render the preparation acceptable to people who as a rule are averse to taking cocoa. So far as we can judge the cocoa used is of the finest, and the analysis shows that it compares favourably with the cocoas at present on the market. It will be seen that the addition of substances other than cocoa has not resulted in a diminution of proteid as is usually the case, and thus the consumer gets the food value of cocoa as well as the other advantages enumerated above.

Our analysis shows the preparation to have the following composition:—

Fat, 20·36 per cent.
Proteids (containing 2·83 per cent of nitrogen), 17·91 per cent.
Mineral matter, 5·14 per cent.
Moisture, 4·34 per cent.

Medical News.

The 15th International Congress of Medicine.

A meeting of the National Committee of Great Britain and Ireland of the fifteenth International Congress of Medicine was held in the rooms of the Medical Society of London, on Thursday last, Nov. 30th Dr. Pavy, F.R.S., in the chair; among those present were Sir Dyce Duckworth, M.D., Dr. Ferrier, F.R.S., Dr. Radcliffe Crocker, Dr. Gordon Dill, Dr. Frew, of Kilmarnock; Mr. W. H. H. Jessop, Mr. L. E. Creasy, Dr. Boyd Joll, and the honorary secretaries, Mr. D'Arcy Power, and Dr. Clive Riviere. The Secretaries made a report upon the travelling facilities offered to members going to the Lisbon Congress, which is to be held in Easter week next year. The arrangements with the railway companies are not yet complete, but a substantial reduction in fares is promised, though there will be the same troublesome formalities as were enforced at the Madrid Congress. Messrs. Thomas Cook and Son, acting in conjunction with Messrs. Anderson and Green, of the Orient Pacific Line have chartered the s.s. *Ophir* which conveyed T.R.H. the Prince and Princess of Wales on their tour round the world. This steamer will leave Tilbury at 2 p.m. on the Thursday before Good Friday, and will arrive at Tilbury at 8 a.m. on Sunday, April 29th. She will lie at Lisbon for six days in order that her passengers may make the ship their home while attending the Congress, and be spared the discomforts and risks of the shore hotels at a time when they are certain to be overcrowded. The usual routine of meals will be maintained on board and regular communication with the shore will be kept up. During the stay of the *Ophir* at Lisbon a series of excursions will be made to suit those passengers whose time is not fully occupied at the Congress. The fare for the seventeen days' cruise (exclusive of shore excursions) will be from fifteen guineas upwards, according to the position of the cabin. Early application for berths is desirable, as a considerable number of the cabins are already engaged. Application should be made to Messrs. Thomas Cook and Son, Ludgate Circus, London, E.C., or to the Orient Pacific Line, Fenchurch Avenue, E.C.

The Travel Bureau of 29, Cockspur Street, Charing Cross, S.W., has arranged two tours in connection with the International Congress at Lisbon. The first party will leave London on Sunday, April, 15th, will sleep at Paris, and arrive in Lisbon at midnight on Tuesday, April 17th. The return journey will commence on Friday, April, 27th and will end at Paris on Wednesday, May 2nd. The inclusive first-class fare with excursions to Cintra, Mont 'Estoril, and two days at Bussaco is thirty-two guineas. The Travel Bureau has also arranged for the conveyance of passengers to Lisbon by the Royal Mail steamer *Ambrose*. Passengers can join this ship at Liverpool or at Havre. The first-class fare throughout is eleven guineas from Liverpool back to Liverpool, or twelve guineas from London to London. The National Committee nominated a physician, a surgeon and a general medical practitioner to serve as Presidents d'honneur at the Lisbon Congress, and considered a letter from Dr. F. G. Bushnell about the formation of an International Health Ministry.

Irish Medical Schools' and Graduates' Association.

The Autumn General Meeting of the Irish Graduates' Association was held on November 28th in London. The chair, in the absence of the President (Sir William Whitla) was occupied by Dr. J. H. Swanton, Chairman of Council. There was a large attendance of members, including Sir John Moore, Sir Thomas Myles, Inspector-General Whitley, R.N., and others. The members and their friends, to the number of 233, including many ladies, subsequently dined together at the Hotel Cecil. There were but two toasts, that of the King, proposed by Dr. P. Abraham, who took the Chair in the unavoidable absence of Sir William Whitla, and that of the Association, proposed by Sir Dyce Duckworth. A mixed concert and variety entertainment followed. The Dinner proved the largest and most successful in the history of the Association, which now has more than 850 members on its roll. The success of the affair was mainly due to the untiring efforts of the Entertainment Secretary, Mr. Canny Ryall.

Medical Sickness and Accident Society.

The usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity and Life Assurance Society was held on the 14th prox., Dr. de Havilland Hall in the chair. The accounts presented showed that a larger number of new members had entered the Society this year than in any previous period of the same duration, and that the sickness experienced had been moderate. Unless, therefore, there is a great falling off in the course of the next few weeks, the year's working will be very satisfactory, and the annual report will show a considerable addition to the already large reserve of the Society. Prospectuses and all particulars on application to Mr. F. Addiscott, secretary, Medical Sickness and Accident Society, 33 Chancery Lane, London.

Catholic University Medical School.

Last Friday evening the inaugural address of the present session of the Medical and Scientific Society of the Catholic University School of Medicine was held in the School, Cecilia Street. Dr. Anthony Roche delivered the inaugural address and discussed the question of improved dwellings for the poor as a means of combatting tuberculosis. He pointed out that Connaught was the province worst provided with labourers' dwellings. The rest of the address was devoted to the subject of "Some Parasitic Diseases and Man," which was illustrated with lantern slides.

Trinity College, Dublin.

The following candidates passed the Final Examination in Surgery at Michaelmas, 1905:—Howard English; John W. Burns and Benjamin Johnson (equal); Daniel M. Corbett and William I. Thompson (equal); George E. Nesbitt; Thomas King-Edwards; John Chambré and William C. MacFetridge (equal); Thomas T. H. Robinson; William R. Galwey, James M. Harold, and Carlile Kelly (equal); Alfred C. Elliott and Cyril H. M'Comas (equal); Henry H. White; Edward D. Atwell.

Notices to Correspondents, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, to avoid the practice of signing themselves "Reader," "Subscriber" "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in re-forwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

Pensator.—We consider that our correspondent has been wrongly advised. The difficulty would never have arisen had a firm of solicitors been employed who are accustomed to deal with such cases. But the best thing of all is to join the Medical Defence Union.

Dr. Young.—Our correspondent is thanked for his communication which will receive attention in our next issue.

Tu quoque.—The complete installation would cost, approximately, £100.

A MEDICAL REVERIE.

Very doubtful just how to begin it,
  But think I could cover a page
If the thoughts that are crowding each minute,
  Would each only one sentence engage.
The wonderful treatment of cancer
  So "puffed" off by a Frenchman of late
Has failed in its trial to answer,
  So hundreds are left to their fate.
The plague is found due to "Bacteria"!
  And rats the Bacilli convey,
So don't let the vermin come near you,
  You'll find them much better away.
The open-air treatment of Phthisis
  Though all very well for a time
Is no better than feeding on ices
  (Of course this is meant to make rhyme).
The surgeon begins at your tonsils
  "Adenoids" next call for his aid,
He'll short-circuit all your intestines,
  He'll find your "Appendix" decayed.
All honour and praise for that button,
  Chicago's (connect-a-gut) fame,
Though not often used by Bland Sutton
  The appliance itself not to blame.
You may part with "Appendix" and "Prostate,"
  And feel you have gone through the wars,
The tatter you'll know when you've lost it,
  "A vacuum nature abhors."
When you've bidden good bye to your "giblets,"
  And at last have to bow to your fate!
At least there is one ray of comfort,
  There won't be so much to cremate!—A. D.

F. T. B.—We regret to be unable to concede to our correspondent's request.

L.R.C.P.Lond.—Apply to the Registrar of the Royal College of Physicians of London.

Exeter.—We will endeavour to obtain the imformation required.

Statistician.—The losses of a great modern war are small in comparison with the loss of life caused to one population of civilised communities by the single disease, tuberculosis, with is above all things preventible.

Meetings of the Societies, Lectures, &c.

Wednesday, December 6th.

Obstetrical Society of London (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Mr. W. G. Nash, Mr. Doran, Dr. F. E. Taylor, and Dr. Horrocks. Short Communication:—Dr. F. E. Taylor: On the Presence of Sarcomatous Tissue on the Walls of Ovarian Cysts. Discussion on Ventral Fixation and its Alternatives (opened by Dr. Herman).

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m. Mr. P. J. Freyer: Clinique. (Surgical). 5.15 p.m. Mr. H. L. Barnard: Diseases of the Gall Bladder and Bile Ducts.

Post-Graduate College (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Baldwin: Practical Surgery.

Thursday, December 7th.

Childhood Society and the British Child-Study Association (Parkes Museum, Margaret St., W.).—8 p.m. Discussion on Infant Classes (opened by Dr. J. Kerr, Prof. H. R. Kenwood, Miss Phillips, and Miss Finlay). (Arranged by the Childhood Society.)

Harveian Society of London (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Discussion on the Attitude of the Medical Profession towards Insanity (opened by Dr. J. S. Tuke).

British Gynæcological Society (20 Hanover Square, W.).—8 p.m. Papers:—Dr. R. T. Smith: On a Case of Associated Pyosalpinx and Appendicitis.—Dr. Purcell: A Case of Broad Ligament Cyst with Injury to Ureter and subsequent Rectification. Adjourned Discussion on Dr. S. Savage's paper on Hæmatoma of the Ovary.

Neurological Society of the United Kingdom (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Pathological Meeting.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Fungous Diseases of Hair: III., Favus; IV., Leptothrix. (Chesterfield Lecture.)

Friday, December 8th.

Clinical Society of London (20 Hanover Square, W.).—Papers:—Mr. J. Clarke: The Present Position of the Treatment of Congenital Hip Dislocation.—Dr. E. W. Goodall: A Case of Typhoid Fever with Peritonitis but no Perforation in which Laparotomy was performed.—Mr. W. G. Spencer: Septic Peritonitis occurring early in the Course of Typhoid Fever apart from Perforation.—Mr. T. H. Kellock: A Case of Traumatic Pancreatic Pseudo-cyst.

Tuesday, December 12th.

Medico-Legal Society (Rooms of Royal Asiatic Society).—8.15 p.m. Dr. F. J. Smith: Post-mortem Examinations which do not Reveal the cause of Death.

Vacancies.

Cancer Wing of the Middlesex Hospital.—Medical Officer and Registrar. Salary £100 per annum, with board and lodging. Applications to F. Clare Melhado, Secretary-Superintendent.

Durham County Asylum.—Second Assistant Medical Officer. Salary £180 per annum, with rooms, board, laundry, and attendance. Applications to the Medical Superintendent, Durham County Asylum Winterton, Ferryhill.

Manchester Children's Hospital, Pendlebury, near Manchester.—Visiting Surgeon. Salary £100 per annum. Applications to the Secretary, Manchester Children's Hospital, Pendlebury, near Manchester.

North Riding Asylum, Clifton, York.—Second Assistant Medical Officer. Salary £150 per annum, with board, lodging, washing and attendance, Applications to the Medical Superintendent.

Royal Pimlico Dispensary, 104 Buckingham Palace Road.—Resident Medical Officer and Secretary. Salary £100 per annum, with unfurnished house and percentage. Applications to the Secretary.

Seaman's Hospital Society.—
  Two Assistant Physicians.
  Two Assistant Surgeons.
  One Assistant Ophthalmic Surgeon.
  One Assistant Physician for Diseases of the Skin.
  One Assistant Physician for Diseases of the Throat, Nose, and Ears.
  Applications to P. Michelli, Secretary.

Appointments.

Ballantyne, H. S., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Dalkeith District of the county of Edinburgh.

Blakeney, John Henry, L.R.C.P.Lond., M.R.C.S., District Medical Officer by the Cheltenham Board of Guardians.

Collins, Octavius Augustus Glasier, B.A., B.C.Cantab., Medical Officer to the Bath Statutory Hospital for Infectious Diseases at Combe Down.

Elkington, E. A., M.B.Lond., Certifying Surgeon under the Factory and Workshop Act for the Newport District of the county of Salop.

Hedden-Richard, L.R.C.P.Lond., M.R.C.S., L.S.A., Medical Officer to the Union Workhouse by the Honiton (Devon) Board of Guardians.

Kerr, Harold, M.B., Ch.B.Edin., D.P.H.Cam., Assistant Medical Officer of Health to the County Borough of Bury.

Lumsden, J. H., M.B., M.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Denny District of the county of Stirling.

Pottinger, J. A., M.D., Ch.B.Edin., Resident Surgeon to the Provincial Hospital, Port Elizabeth, South Africa.

Sanders, J. Herbert, M.D., M.R.C.S., L.R.C.P.Lond., Honorary Assistant Anæsthetist to the Central London Throat and Ear Hospital, W.C.

Sandwith, F. M., M.D.Durh., F.R.C.P.Lond., Lecturer on Tropical Diseases at St. Thomas's Hospital Medical School.

Stephenson, Sydney, M.B., C.M.Edin., Ophthalmic Surgeon to the Queen's Jubilee Hospital.

Symons, William Henry, M.D.Brux., D.P.H.Oxon. and Durh., Superintendent to the Bath Statutory Hospital for Infectious Diseases at Combe Down.

Temple, George H., M.B., C.M.Edin., Honorary Surgeon to the Weston-super-Mare Hospital.

Tighe, John Brosnan, M.B., B.Ch.Irel., Senior Assistant Medical Officer to the North Riding Asylum of Yorkshire.

Births.

Bray.—On Nov. 14th, at Meerut, India, the wife of Major George Bray R.A.M.C., of a daughter.

Browne.—On Nov. 28th, at 70 Russell Square, London, the wife of J. Arthur Browne, M.B., B.Ch., of a son.

Chance.—On Nov. 30th, at 90 Merrion Square, the wife of Arthur Chance, of a daughter.

Collier.—On Dec. 3rd, at Somers, Wimbledon Hill, the wife of S. R. Collier, M.D., of a son.

Hinks.—On Nov. 28th, at Lamorna, St. Vincent's Road, Southend-on-Sea, the wife of A. Grosvenor Hinks, M.B., M.R.C.S., L.R.C.P., of a daughter.

Deaths.

Payne.—On November 30th, at Barford, Warwick, William Arthur Payne, M.B., Oxon., aged 50 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, DECEMBER 13, 1905. No. 24.

Original Communications.

SOME PRACTICAL OBSERVATIONS UPON MENINGITIS.—I. (a)

By F. J. POYNTON, M.D., F.R.C.P.LOND.,

Assistant Physician to University College Hospital, and to the Hospital for Sick Children, Great Ormond Street, London.

THE subject chosen for this discussion can hardly be dealt with at the present time in any very original or brilliant manner, for our knowledge of it advances but slowly, and our treatment is lamentably inefficient. Meningitis must, however, always be a subject of supreme practical importance, and however experienced, and however careful we may be, we shall assuredly come to grief over it at one time or another. I felt, then, that this subject must give rise to a discussion in which all of us would learn something, and all have some interesting facts to record.

It would be clearly impossible to treat of meningitis in any detail, and I shall content myself with commenting, in an entirely practical way, upon certain points, which have struck me as important, and upon certain of the more modern investigations that have been made. In this country, the tuberculous, post-basic, pneumococcal, streptococcal, staphylococcal, and syphilitic forms are those which are most frequent. I am, personally, a believer in the existence of a true rheumatic meningitis, though I believe it to be extremely rare.

These morbid specimens illustrate the various types, and I thought they would be of interest because circumstances make it almost impossible for those engaged in family practice to get opportunities of seeing such things, and they too are of great value in helping us to obtain an accurate picture of clinical symptoms.

It will be readily seen from these specimens that the deposit in tuberculous meningitis is most extensive at the base of the brain and in the Sylvian fissures.

Whereas pneumococcal and other forms of suppurative meningitis are more extensive in their distribution and spread more extensively over the vertex of the brain, the remarkable localisation of post-basal meningitis is also illustrated here in a very striking manner. The widespread lesions of the pia mater in meningitis explain the varied clinical symptoms, especially if with the extent of the lesion is coupled the variable intensity of the processes.

Morbid anatomy also demonstrates the very practical fact that the brain itself is much damaged by the various infections which cause meningitis. It is generally much softened, and the cortex is sometimes almost diffluent. There is, that is to say, a cerebritis as well as a meningitis, and this at once shows us that no method—be it lumbar puncture or other form of drainage—can possibly cope with the acute disease; and it explains also the great instability of the highest nervous centres that remains for long periods after a fortunate recovery from an attack of meningitis.

A necropsy demonstrates, too, the increase in the cerebro-spinal fluid, which in all acute cases must add to the pressure upon the delicate structures of the brain, and which in post-basic meningitis so frequently leads to a gross hydrocephalus. So important is this complication in that disease that it is most advisable to make a rule of measuring the head at the commencement of the illness, in order to be prepared for the detection of this serious condition at the earliest possible moment.

The occurrence of tuberculous masses in the brain, together with tuberculous meningitis, helps in some cases to explain unusual phenomena in the course of that illness.

If, however, we attempt to explain every paralysis, or one-sided convulsion that may occur in meningitis by an accurate localisation of the lesions to the corresponding part of the brain, we shall meet with disappointment. Our knowledge, at present, is not sufficient to do more than enable us to gain a general idea as to whether the process is basal or more general.

This is a point I would emphasise, and illustrate by a reference to another condition, namely, apoplectiform uræmia. In that condition a man is struck down with an hemiplegia or other paralysis, whether more or less complete. It seems certain that there is a gross cerebral lesion, and yet the *post-mortem* examination shows no gross change. The imperfection of our knowledge in this direction is realised when we attempt to diagnose between a cerebral abscess and tuberculous meningitis. Middle-ear disease is frequent in children who are attacked with tuberculous meningitis, and if the meningitis should give rise to a more than usually definite paralysis it is most reasonable to think that the condition is one of abscess. Experience, however, only too often shows that these difficult cases are meningeal, and after death no localised gross lesion is found to account for the marked paralysis that was present during life. It is most unsatisfactory, and however much one may justify oneself, it is bad treatment to subject a patient to an operation for cerebral abscess, when the condition is in reality tuberculous meningitis. This mistake can sometimes be avoided by refusing to become engrossed by the cerebral symptoms, and by turning to a careful examination of the other systems. Thus I have known the discovery of tuberculous glands, tuberculous pulmonary disease, a tuberculous testis, and even tuberculous dactylitis save the situation even at the last moment.

Turning now to the more clinical side of our subject, it does not seem to me useful to enumerate the various symptoms of meningitis, for they are well known; and I will pass on to some of the deceitful appearances of tuberculous meningitis which may be taken as our type. The earliest warnings of the insidious cases cannot be certainly diagnosed. A great danger that besets us is that of giving a confident diagnosis, one way or the other, when it is not possible to do so. One is especially liable to mistake tuberculous meningitis when gastro-enteritis is prevalent. The tendency to

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(c) Read before the Thanet Division of the B.M.A., Sept. 26th, 1905.

constipation, the occurrence of paralysis, convulsions, or rigidities, irregular sighing breathing, and a tense fontanelle are highly suggestive of meningitis. In severe cases of gastro-enteritis, however, toward the close of the illness, twitching, convulsions, squinting and other cerebral symptoms may develop, as a result of thromboses in the venous sinuses or as a result of the poisons that have caused the gastro-enteritis. In such cases the history is almost the only guide to the diagnosis.

Examination of the retina in suspected tuberculous meningitis is often disappointing, for optic neuritis is slight and often late in its appearance, and when the child is irritable the examination distresses both it and the parents. One cannot, however, escape from the fact that now and then a case which baffled diagnosis has become apparent through the detection of choroidal tubercle, or the discovery of neuritis.

Retraction of the head, also a valuable sign of meningitis, is met with in such conditions as acute pneumonia, actute otitis media, retropharyngeal abscess, and in some cases of typhoid fever, and a little care, too, is needed to avoid confusing this spasm of muscles with the falling back of the head in the paralysis of cerebral diplegia or in the weakness of exhaustion. The points in the diagnosis between meningitis, typhoid, and pneumonia need not detain me further than to add to this classical group influenza.

Influenza in small children is, I think, admittedly a most difficult condition to diagnose with any confidence. If I pick out one symptom which has struck me above all, it is the extraordinary and rapid depression that ensues in small infants attacked by influenza. They may lie semi-conscious, with the eyes sunken, the breath almost cold, and with all the appearance of advanced cerebral disease. The pulse is feeble to a degree. It is the remarkable suddenness and this exceedingly feeble action of the heart which may put us on guard, and, if there is a history of influenza in the house, encourage us to make that diagnosis, for such cases we know may recover with free stimulation and warmth.

But *influenza* can produce a fatal cerebritis such as has been described by my colleague, Dr. Batten ; and then the diagnosis is extremely difficult, but not of such urgent importance, for it is in some measure a refinement of diagnosis to distinguish cerebritis from meningitis. Between the fatal cases of cerebritis and those cases in which there is complete recovery after a period of extraordinary depression, may be placed such a case as the following :—

The mother of an infant, æt. 15 months, fell ill with influenza, which was rife in the neighbourhood. Before the mother recovered the child fell ill with fever and vague cerebral symptoms which were ascribed to pushing teeth. After eleven days of indeterminate illness, in which heaviness and drowsiness were prominent, one midnight the infant became very faint and screamed, apparently with pain in his head. The next morning the right arm was powerless ; and the next day the left ear seemed tender, and the membrane, which was dull red, was perforated by the medical attendant. Later the paralysis spread to the right side of the face and legs, and optic neuritis was visible in the left eye. Together with these symptoms there was conjugate deviation of the head and eyes to the left. That is to say, a right hemiplegia had developed in which the arm was the most severely paralysed. Meantime, pus was escaping from the left ear. The special point that required consideration was the possibility of a temporo-sphenoidal abscess on the left side in association with the ear disease. The general condition, and the whole aspect of the case did not, however, seem to fit in with such a diagnosis, and quite suddenly the temperature fell, leaving the child peculiarly dull for some weeks. At no time was there vomiting or retraction of the head, and recovery was eventually complete except of the right arm, which became spastic. I believe that this was a result of influenza, and probably a polio-encephalitis superior and associated influenzal otitis-media.

This case leads me to consider in some detail, acute infantile paralysis, a condition to which decided additions are being made to our knowledge.

Acute infantile paralysis may appear as an anterior polio-myelitis, a polio-encephalitis inferior or a polio-encephalitis superior. I should like to illustrate these points by a very brief reference to two cases recently under my observation.

A breast-fed child, æt. 14 months, one of a considerable family, was suddenly seized with vomiting, fever and general cerebral poisoning. There were retraction of the head and small pupils ; but the remarkable symptom was great difficulty in swallowing, apparently due to paralysis of the muscles of deglutition. The child was very ill, and when I first saw him with Dr. P. J. Edmunds, had been ill four days. Later that evening, both upper extremities were paralysed all but the fingers, and the next day the diaphragm failed, and death ensued on the sixth day of illness. This case, it will be noticed, was unusual, for it is not the rule to find in meningitis such a complete bilateral paralysis of the upper extremities as eventually developed, or such a failure of the diaphragm. On the other hand, if it had been a spreading myelitis the cerebral symptoms were remarkable, and even more remarkable was the fact that both lower extremities could be kicked about with absolute ease; and showed no signs of paralysis with increased reflex. There seemed no escape, then, from the belief that the anterior cornual cells, only, had been picked out by an acute disease in the upper part of the cervical enlargement, and that the lesion had reached upward to the fourth cervical level, thus destroying the innervation of the diaphragm. The small pupils suggested some damage to the sympathetic nervous system. The necropsy confirmed the belief, and showed the acute early lesions of anterior poliomyelitis in the region indicated.

Cultures from the cerebro-spinal fluid were negative, but in some of the films of the same fluid I saw a few micrococci in the polynuclear cells. This is not of real assistance in the furtherance of our knowledge of the exact cause of the disease, but has this interest, that Concetti in Italy in 1901, Netter in France about the same date, and Louft and Dethloff in Norway in 1901, have isolated the meningococcus from cases of acute anterior poliomyelitis investigated at the onset of the disease. Louft informs me that his cases are alive, but the diagnosis from the symptoms appeared certain.

These somewhat rare forms of infantile paralysis are, then, exceedingly likely to be mistaken for meningitis. Yet it is important to attempt to differentiate them, for they may recover, though with some degree of paralysis. My colleague, Dr. Batten, who has done so much to advance our knowledge of this subject, has, for instance, recorded cases in which the facial nucleus has been picked out, and it is clear that we must add to the causes of convulsions and head retraction in infants these forms of polio-encephalitis. The extensive paralysis and abrupt onset with high fever, suggest acute infantile paralysis, however striking the general cerebral symptoms may be.

The second case is less convincing, but the result more satisfactory :—

A boy, æt. under 3, of tuberculous stock, had for six days before the particular illness suffered from a cold. There was no evidence that this was influenzal, and he was apparently well, when on the night of the sixth day he woke up terrified, and staring vacantly about him. During the next three days there were vomiting, fever, and incessant moaning, and the temperature rose on one day to 104°. His consciousness became so much damaged that he did not know his mother, and some spasm of the left facial nerve was noticed. On the third day a sudden hemiplegia of the right side developed, damaging the right arm more than leg. The child was so irritable that I could not catch a glimpse of the fundi. Suddenly the temperature dropped almost as rapidly as it had risen, and the child made a remarkable recovery, and is now running about in the best of health except for a spastic and paralysed right arm.

Mercury was rubbed in and iodide of potassium was pressed during the illness, although the grounds for doing so were not sure. I think this was a case of polio-encephalitis superior, and here again there was sudden onset with fever and very definite paralysis.

SURGERY OF ENLARGED PROSTATE. (a)

By HENRY M. O'HARA, F.R.C.S.I.,
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The dissection of the male perinæum was to me in my student days a difficult crux, and after twenty-four years as surgeon to a large metropolitan hospital, and having my share of private work, I must confess I still consider it a most complicated region. It is only a small triangular space bounded by a base line drawn from tuberischium to tuberischium, and the sides of the triangle made by lines drawn from those points to the pubes, but its contents are exceedingly intricate. To understand the supports of the pelvic viscera, it is necessary to know the position of the pelvic fascia which go to form the floor of the pelvis. These are the obturator fascia, the pyriformis fascia and the recto-vesical fascia. The most important structure in connection with the surgery of the prostate gland is the recto-vesical fascia. It comes off the inner surface of the obturator fascia forming the white line with its concavity upwards. It blends posteriorly with the pyriformis fascia. It passes downwards, covering the levator ani and coccygeus muscles, and beneath the bladder prostate and rectum, where it splits into two layers, one being reflected on the rectum, the other or lower layer sends a lamina downward to enclose the prostate and forms its capsule, and becomes continuous with the deep layer of the triangular ligament. This fascia completely closes the pelvic outlet and supports the pelvic viscera. My reason for giving this description I shall explain when comparing the different routes in the operation of prostatectomy.

Chronic enlargement of the prostate gland has been looked upon as a necessary disease of old age, and realising the fact that atrophy is the usual accompaniment of senility, I doubt whether every unfortunate old man is condemned to spend the winter of his days in the tortures of enlarged prostate. The idea seemed unnatural to me, and I therefore determined to find out by an examination of as many cases as presented themselves in private and hospital practice. I have now the result of 200 examinations in patients ranging from 30 to 82 years, and I come before you to-day to refute the long-established theory of senile hypertrophy of the prostate gland. It is not necessarily a senile condition, and I have discovered a greater percentage of enlarged prostates in men between 35 and 50 than those over 70. I have always wondered why the prostate gland should be the only one in the human organism to undergo hypertrophic changes as the result of senile decay. In other glands we expect atrophic changes to accompany old age, particularly in the uterus, which is looked upon as the anologue of the prostatic utricle. As the result of my examination of 200 cases suffering from urinary troubles I found the following results :—

Between 35 and 50—86 cases, with 18 enlarged prostates ; 51 had suffered from gonorrhœa ; one had tuberculous disease.

Between 50 and 60—62 cases, with 12 enlarged prostates ; 5 had marked atrophy ; 34 had had gonorrhœa.

Between 60 and 70—16 cases with 3 enlarged prostates ; 2 admitted gonorrhœa ; one had atrophy ; one had malignant disease ; 2 fibro-myoma.

Over 70—12 cases, with 2 enlarged prostates ; 1 had atrophy ; 5 had had gonorrhœa.

Thirty-two of these cases required prostatectomy. Of these, 18 admitted to having had gonorrhœa ; 5 of them had had syphilis also. Only the most serious urinary cases come into a general hospital ; hence the large percentage requiring operation. In the healthy adult, the prostate gland is a sexual organ composed of muscular and glandular tissue. In its normal state it plays no part in the act of urination, but its function is to secrete a fluid for the dilution of the semen and nourishment of the spermatozoa. The verumontanum, a vertical elevation on the posterior wall of the prostatic urethra, is its most sensitive part, and becomes intensely congested during the sexual act. This region is a fertile ground for the development and subsequent lodgment of the gonococci. The inflammation extends from this point to the middle and the two lateral lobes, and these in their turn become engorged and swollen. Should the condition go on to abscess and discharge its contents, the gland will contract as disintegration takes place, and unless a cicatricial contraction of the urethra at the neck of the bladder is produced, an atrophied prostate may be the only result. Gout, trauma from instruments, and inflammation extending from cystitis, the result of stone, may also cause inflammation of the prostate gland, but this form generally subsides without suppuration. A very different condition, however, takes place if the acute gonorrhœal congestion left untreated goes on to the chronic inflammatory stage. The muscular and glandular tissue may remain permanently enlarged and eventually become a mass of fibrous tissue. The fibrous capsule of the gland also thickens in the inflammatory process and becomes firmly attached to the recto-vesical fascia, causing great difficulty in separating it from the latter. A gonorrhœal attack, invading the prostatic urethra, spreads to the substance of the gland, and this condition being rarely treated, produces a change in the muscular fibres and glandular tissue, and in a strumous subject probably it renders the gland liable to become secondarily affected with tubercle. I invariably examine the urethral discharge in every case of chronic prostatitis, and I have discovered gonococci in very old-standing cases. It is an easy matter to express any fluid from the posterior urethra with the finger in the rectum. In acute cases, having assured myself of the gonorrhœal affection, I adopt the following treatment :—

Absolute rest in bed when possible. A bland, non-stimulating diet. Leeching the perinæum. Free action of the bowels encouraged by salines ; the local application of a 25 per cent. solution of argyrol to the prostatic urethra. Hot hip-baths and hot douching to the posterior portion of the gland per rectum (this can be very well done with Bozesman's uterine irrigator). Suppositories of ichthyol. Should the condition not yield to this treatment after a fair trial, it may be necessary to drain the bladder in the supra-pubic region and give the urethra physiological rest. I have never seen massage to the prostate do any good. From the data obtained from my patients, I feel satisfied that the enlargement of their prostate glands commenced with the later stages of their gonorrhœa, and had these been treated surgically at the time I think the majority of the cases could have been saved the enormous hypertrophic conditions that I found. The treatment of gonorrhœa is much too lightly undertaken, and it is my invariable custom to warn every patient what the direful results may be if neglected. The symptoms of chronic prostatitis may be very slight, and you will often find it difficult to persuade your patient that there is any need for care or treatment. You are all aware, gentlemen, of the complications that may arise from an attack of gonorrhœa, but as I am only dealing with prostatic enlargements in this paper I will confine myself to that gland. If the lateral lobes only are enlarged only slight symptoms may continue for years, but should the middle lobe become affected it bulges backwards and upwards into the bladder and carries the urethral opening up above the water-line, forming a valve-like condition which eventually partially or completely blocks the flow. Before advising a patient

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(a) Read before the Surgical Section at the Australasian Medical Congress held in Adelaide, September 4th, 1905.

to undergo the operation of prostatectomy, except in most urgent cases, I invariably give palliative treatment a fair trial. By this, I mean daily irrigation of the bladder with some mild antiseptic lotion, preferably weak solutions of nitrate of silver, one in ten thousand, followed by a wash-out with normal saline solution; the passage of large sounds curved at first, and gradually becoming straighter, so as to bring down the prostatic opening of the urethra to the level of the floor of the bladder. This treatment will sometimes break in a patient to adopt catheter life on his own account with a certain amount of comfort and safety. Men of placid temperament endure catheter treatment for years without injury to their nervous system. So long as they can attend to strict asepsis and keep the bladder clean they are best left alone. Operation is demanded when from the retention of urine, either partial or complete, these conditions cannot be fulfilled, or where the patient's life is jeopardised through loss of sleep or general nervous irritation, the result of constant attempts to empty the bladder; where there is any indication of beginning renal disease; also in certain occupations where it is absolutely necessary to hold the water for long intervals, such as coachmen, engine-drivers, &c. There are two forms of myomatous prostate very similar to those found in the uterus, the hard fibro-myoma, the discrete tumours, and the soft œdematous myoma. They grow slowly and insidiously, and being of a non-inflammatory nature, do not affect the capsule of the gland, which merely stretches, leaving the recto-vesical fascia intact. We find enucleation from their fascial surroundings are therefore generally easy. The other cases of enlargement of the prostate gland, tubercle and carcinoma, I have only met with on two occasions, but I am inclined to think a small percentage of senile prostates become malignant. Of the 32 operations performed, two died, one, a carcinoma, of shock on the third day, in which I was associated with Dr. Clayton. The other was a large fibrous prostate, the condition being complicated by chronic nephritis. The patient lived for three months and eventually died of renal disease. One can hardly attribute his death to operation. I now show you his bladder and the prostate, and you can judge for yourselves the result of the operation. Where the condition of a patient is so serious as to require operative interference several methods of treatment have been advocated of late years; but I will merely mention these, as I have had very little experience in all but prostatectomy. The American and English surgeons originally advocated castration, and I have adopted the plan in three cases. One was certainly relieved, but the other two developed acute mania and never recovered. After an operation for the radical cure of hernia in a man, æt. 55, with Dr. Weigall, of Elsternwick, acute cellulitis developed in the scrotum. The parts sloughed and the testicle on the left side was destroyed. It is ten years since the operation, and on examination Dr. Weigall assures me the lateral lobe on the side of the missing testicle is now completely wanting, and the lobe on the sound side is enormously hypertrophied. I think this is a good test that White's operation had something to recommend it.

Vasectomy is too uncertain in its result. It can be done under local anæsthesia, but I would not recommend it unless the patient refused the more radical operation. The division of the bar at the neck of the bladder by the galvano-cautery, or electric knife, as recommended by Bottini is, to my mind, a dangerous procedure, even with the aid of a cystoscope, and I cannot recommend it. The most satisfactory operation at the present time is prostatectomy, either by the supra-pubic or perineal method, and each has its advocates. Having performed the supra-pubic operation 32 times, with but one death, I must, for the present at any rate, pin my faith to that method. My colleagues at the Alfred Hospital, Messrs. Cooke and Hamilton Russell, have had equally good results.

In nine of my cases I had some post-operative complications; two elderly gentlemen, æt. 77 and 69 respectively, became temporarily demented, but have completely recovered. Three had urinary fistula for four and five months. Two have completely recovered, but one is still unhealed. One patient developed thrombosis in the deep femoral vein, with much œdema of the leg. He has now quite recovered. Three are obliged to empty the bladder with catheter, having no muscular power in their large sacculated atonic bladders. So that out of 32 prostatectomies, 26 are quite restored to health. One, the malignant case, died as the result of operation, and four are relieved. I have not found the help that other surgeons seem to get from the cystoscope; in fact, I have given it up in prostatic cases, and rely on digital examination to form my diagnosis. I find with my finger in the rectum and having emptied the bladder, I can always map out the condition. If the urethral groove can be clearly defined per rectum, the trouble is invariably in the middle lobe. Before giving a prognosis as to the probable result of the operation, it is well to find out the amount of muscular expulsive force the bladder has. This can be discovered by passing a catheter, filling the bladder with some solution, and then directing the patient to force the fluid out. If the stream is a fairly vigorous one, the muscular wall must be still active. If the stream merely dribbles out it is an indication of atony and the prognosis is bad. However, by removing the enlarged gland, catheter life is made bearable and the outlet of the urethra having been lowered to the floor of the bladder, the decomposing urine that had previously lain in the bas fond can be evacuated. I am well aware of the brilliant results of perineal prostatectomy in the practice of other surgeons, but the advantages which I claim for the supra-pubic operation are:—

1. Rapidity of performance. Since writing this paper I removed an immense prostate at the Alfred Hospital on September 1st in the presence of a number of surgeons, two of whom took the time, and the operation took exactly four minutes. The prostates that require removal are generally inside the bladder, and easily accessible from the front. With the bladder filled and the patient placed in Trendelenberg's position, an incision about three inches long is made in the mid-line beginning at the pubes. Having separated the recti, divided the transversalis fascia and exposed the bladder, I fix it with an instrument I now show you, which assists in holding it in position to be opened. I then fix with a suture on either side of the upper part of the incision the bladder to the skin. This prevents injury and leakage into the tissues. I expose the gland by an incision through the mucous membrane on its anterior superior aspect and enucleate with my finger, working from above downward. Another finger in the rectum will help to push up the prostate, taking care to avoid tearing the urethra if possible. I have found it a good plan, when the bladder is in a foul condition, to keep up constant irrigation for the first few days after operation, and I have devised this irrigator which I now show you. It is made of metal, has two tubes—a small one for inflow of saline solution and a large outflow tube. It prevents the lodgment of any septic material in the raw cavity left after removal of the gland. I think it also helps to control hæmorrhage.

2. It is practically impossible to avoid wounding some branches of the prostatic plexus of veins and unavoidable bleeding can be controlled by sponge pressure on holders. This is where the value of the fascia on the posterior surface of the bladder can be realised. The fascia and ligaments on the floor give a firm resistance to pressure from above which you cannot obtain in the perineal operation.

3. No important structures are injured on the route to the gland if the incision is made in Retzius' space, which is above the attachment of the recto-vesical fascia to the pubes. I have always thought that splitting the valuable supports to the pelvic viscera, that is to say, the fascis lying below the prostate, must

interfere with the action of the muscles, and ligaments about the rectum and neck of the bladder, and to reach a middle lobe or any tumour bulging into the bladder from a perineal opening, is a matter of extreme difficulty, and increases the danger of injuring those important structures, the seminal vesicles and vasa deferentia.

4. In cases of very old men it is an advantage to sit them up soon, thus avoiding the danger of hypostatic pneumonia. This can be done with supra-pubic drainage, but with a perineal tube a patient cannot well sit up.

5. The supra-pubic wound can be more easily kept aseptic, the proximity of the perineal opening to the anus causing great risk of infection.

Sixteen years ago, before Mr. Gill published his operation, I performed prostate-myomectomy in two cases with Dr. Weigall, and they are at the present time in good health; the remaining portion of the prostate seems to have shrunk.

The deductions I draw from my examinations are :—

That the hard fibrous adherent prostate, in whatever lobe it may be, is invariably the result of a gonorrhœal infection, and may develop at any age.

That a mixed fibro-adenoma probably develops its excess of fibrous tissue as the result of gonorrhœal infection, and may develop at any age.

That the so-called soft œdematous myoma, which attains such an immense size, is probably the result of a blocking through some catarrhal condition, probably gonorrhœa, of the lumen of the gland ducts, so that the prostatic secretion is confined in tubules which rapidly become distended. This is the form of hypertrophied prostate irregular in shape that so quickly develops and may involve only one or all the lobes, and is more often seen after fifty. It does not become adherent to the recto-vesical fascia and is therefore easily shelled out.

That the simple adenoma is a rare condition, most frequently found in the middle or third lobe, and may develop at any age, has a smooth capsule, and is easily enucleated.

That cancer is a rare condition.

That tubercle of the prostate is generally a secondary condition.

Prostatectomy might aptly be called the "finger operation." The diagnosis is made with the finger, and having exposed the gland the rest of the operation ought to be done with the finger. It requires a long, strong finger, with good tactile sensibility, to accomplish the enucleation satisfactorily, and I cannot imagine a more pitiful spectacle than a little man with a short finger attempting to dig out a firmly embedded fibrous prostate. Scoops and forceps of any kind can only be a menace to the patient.

THE MANAGEMENT OF LUNATICS IN WORKHOUSES.

By JOHN MILLS, M.B.,
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The constantly accumulating number of the insane in Ireland has compelled attention to the provision for their care and maintenance, and the admitted intense overcrowding and inadequate accommodation of the District Asylums demands that some solution should be found for the present unsatisfactory state of affairs. A short summary of the conditions under which mentally afflicted patients are most satisfactorily treated, and with the best results, will serve to make clear the aspect from which the subject is regarded in the following remarks.

The necessity for specialising in the various branches of the profession is now so universally conceded that it seems idle to argue that mental affections are best treated by a man whose whole time and energy are devoted to the subject, and whose knowledge is ripened by experience of a large number of cases which coun for so much in diagnosis, and the subsequent treatment.

The subject of nursing the insane in the most humane manner has occupied the attention of the leaders of the specialty for close on a hundred years past, but real progress in this matter only dates from the period when the work of Miss Nightingale aroused public interest in the question. Without tracing the development through its various vicissitudes the present requirements of the Medico-Psychological Association are that attendants on the insane shall undergo a period of probation, and subsequently two years' training with attendance on regular courses of lectures on their duties to the sick before they can be admitted to the examination for the Nursing Certificate of the Association. In this way in Asylums the attendants are taught the necessities of their work, the dangers to be avoided, the constant exercise of tact and patience, and the increased knowledge and intelligence has a most beneficial effect on the performance of their duties, and contrasts very favourably with the dull and inert discipline under which these duties were formerly carried out.

The kind of building most suitable has gradually undergone evolution from the closed-in prison-like structure in favour in the early part of the nineteenth century to the modern well-equipped hospital. Somewhere in the late forties, opinions had so far crystallised as to justify the Board of Works in formulating a series of instructions to Asylum architects from which a few quotations may be made.

"The architect will bear in mind that he is designing a hospital, and not a prison . . . taking care that the appearance of restraint and confinement may be as much as possible avoided. The enclosure walls need not be more than 6 ft. 6 ins. high, and airing court walls 5 ft. 6 ins."

"The main front to have an aspect south-east to south-west."

"In each separate ward a warm bath, a water closet, and a washing room must be provided."

"The windows may be set as low as 3 ft. 6 ins. from the ground."

The question of the treatment is affected in one very vital direction, and that is the method of ensuring distraction from morbid self-concentration and providing employment. Probably no remedial agents equal in efficacy, fresh air, sunshine and occupation; with the view of affording this a considerable amount of land is attached to most hospitals for the insane, on which those capable of working can find healthful exercise; and in an agricultural country like Ireland no form of employment is more suitable to the majority of the patients than that connected with land. It is more than forty years since the Commissioners of Lunacy in Scotland clearly defined that at least an acre of land should be provided for each four of the asylum population. The wisdom of this is very fully confirmed by later experience, and though the standard is rarely attained, it is only so by reason of the short-sighted niggardliness of executive authorities, who fear clamour about expense. A large amount of land is economical in two ways: it provides interesting and congenial employment, the greatest curative agency, and enables farm produce to be supplied at a cost which no farmer with a wages bill to face can compete against with any success.

Having defined some of the conditions which tend to successful treatment, it is necessary to examine how far workhouses fulfil these conditions, and to what extent they are adapted for the treatment of insanity.

The central position of the Union hospitals, coupled with the fact that the office of physician is often held by men of exceptional ability, is a strong inducement to relatives of affected patients to first seek treatment where there will not be a distant removal from the home, and visits can conveniently be paid. There is the further advantage that many mild cases recover when separated from the home surroundings, that the relatives are relieved from responsibility and expense, and what is still unfortunately regarded as the indelible stigma of having been in an asylum is avoided, an occurrence which is never forgotten by the neighbours, and which they speedily taunt the victims with if disputes or disagreements occur. Owing to these considerations, types of all the commoner forms of mental disease, excepting very acute cases accompanied by violence, receive treatment in the Union hospital. This especially applies to cases of melancholia, mild persecutory delusions and organic dementia. Of course, in such cases the ordinary therapeutic remedies are applied, no doubt with skill and judgment, cases of visceral disturbance sought for and treated, and tonics administered for the frequently run down physical condition.

But the restlessness, sleeplessness, inertia and languor of melancholia, for instance, require a treatment which few workhouse hospitals can give. The ablest efforts of a physician in such a case are of little avail unless seconded by skilled nursing, and it is here precisely that the great blot in workhouse treatment occurs. Few who have passed through a period of residence in a large general hospital can fail to recollect occasions when a sudden attack of insanity has occurred in a ward, and to be impressed by the helplessness of the best of trained nurses in such an emergency, and by the anxiety of the staff for the prompt removal of such a case to an asylum; and yet a very scant acquaintance with the advertisement columns of local newspapers satisfies us that at the miserable wages offered it would be impossible to get a good class of attendants for work which is often repulsive and always trying. Often an attendant is not engaged at all for the lunacy wards, and at the best the number of the staff is utterly disproportionate to the number of patients, and for that reason unable to give them the required attention. Imagine the plight of a patient with organic dementia and paresis, helpless, but still conscious of his condition, dependent on the services of a pauper attendant, or on those of one who has to attend thirty or forty others, for whom no substitute is provided when he is absent, and no provision made for the discharge of his duties during the night.

It may be objected that this is stating the extreme of the case or exceptional conditions, but this is not so. The objection as to the unsuitability and inadequacy of the staff applies with greater force in the matter of mild cases capable of improvement and cure, whose hebetude and lethargy is never roused or stimulated, whose intelligence is never appealed to, without any employment or resource but concentration on his own morbid feelings. What wonder that the worst possible environment, the "atmosphere" of the workhouse, hastens the annihilation of his intellectual faculties and adds him to the decaying mass of human wreckage.

It would be easy to cite cases of other forms of mental disease, as idiocy and epilepsy, to whom the workhouse offers not a hospital, but a haven of despair.

When a patient enters the lunatic wards of the workhouse he loses his liberty. Theoretically, he can demand his discharge and go, but practically such a demand is ignored or denied. As medical certificates of insanity have not been issued, he is beyond the pale of the very elaborate machinery which the Lunacy Laws have created for his protection. He is the victim of a species of "contracting out," and though deprived of his liberty for the good of society, no pains are taken to ensure the observance of the other part of the covenant. He is housed in rooms immeasurably below the standard attained and required in asylums; his supervision and attendance are often faultily inadequate, and do not give him sufficient protection. The diet is poor, and clothing and bedding below the barest needs in many cases; his exercise is obtained in a high-walled narrow airing court, often sunless and damp, and of employment there is none. The "Master" can order him solitary confinement or the straight waistcoat, as may appear desirable from a therapeutic or disciplinary point of view to his uneducated intelligence. A recent case where a lunatic ran amok in the idiot ward of a workhouse, and four deaths resulted from the incident, gives emphasis to what has been said about the insufficiency of the staff, and brings out in strong relief another glaring defect of administration which is the promiscuous herding of all classes of cases, and the impossibility of adopting a proper system of classification on which success in treatment so much depends.

I do not wish to appear unduly biassed against the workhouse treatment of lunatics, and wish to quote from the almost forgotten, but comparatively recent, report of the Vice-Regal Commission appointed to inquire into the subject of Lunacy Administration in Ireland, which was presided over by Sir Arthur Mitchell, the eminent Scotch Alienist, and is generally known as the Mitchell Report. The keeping of lunatics in workhouses is unhesitatingly condemned in it—one extract will suffice.

"In some workhouses they may be fairly well circumstanced and treated, but in most their condition is unsatisfactory, and in many so very unsatisfactory that an earnest effort to improve it should be made without waiting for fresh legislation."

The last issued Report (33rd) of the Irish Local Government Board is almost equally emphatic; it says:—

"We have already pointed out to Boards of Guardians that workhouses cannot properly be regarded as institutions for the reception, treatment or custody of the insane, and we have suggested that they should endeavour from time to time to have insane inmates removed to the District Lunatic Asylums," a consummation likely to be accomplished at the millennium, as on December 31st ult. there were 3,439 insane persons in workhouses and the Inspectors of Lunatics, in their 53rd report, lament that the number has increased during the year, but add that it is probably due to old demented people being moved into the lunatic wards for more effective nursing and supervision. From the Report (53rd) just quoted, it appears that 20 per cent. of the admissions into District Asylums were from workhouses, and that this figure has varied little for the past five years; 11 per cent. of the admissions were over 60 years of age. Assuming that admissions from workhouses and admissions generally were equally drawn from persons of the same age periods it would appear that 9 per cent. of the total admissions of curable cases had been treated previously in workhouses under conditions which all authorities on the subject consider distinctly detrimental. These people are isolated by society for its protection, and once isolated a callous carelessness is shown as to what further happens to them. Until a comparatively recent period, the duty of caring for the insane was not the special business of any board or authority. The Boards of Governors of Asylums were only charged with the duty of providing for the Asylum patients, and were not entitled to take cognisance of any other insane. By the Local Government (Ireland) Act of 1898 the County Councils are charged with the duty of providing for the insane within their limits. It can be said that with one exception no effort has been made to grapple with the matter by the newly-constituted authorities, and in this connection it may be added that no effort to any serious extent has been made to accommodate the asylum population, which we learn, from the Fifty-third Report of the Inspectors of Lunatics, increased by an average annual number of 552 for the ten years ending December, 1902, while for the year ending December, 1903, the increase was 148 over the previous year's number. It is a comparatively easy matter to rail and cavil at existing circumstances, and it is generally forgotten that anyone who does ought to be prepared to suggest a better arrangement. The suggestion I wish to make is that County Councils should act on their legal responsibility and protect the insane from themselves and from neglect. The very ample powers they possess of hiring, leasing, and buying lands and houses afford every opportunity for carrying out what is not alone a duty but a moral obligation—if they do not belong to the category of bodies which has neither a soul to save nor a body to be kicked. The most desirable plan would undoubtedly be to collect all insane under the administration of the Asylum Committee, and each body could then decide for itself whether it were cheaper to build additional blocks to accommodate them, or hire vacant buildings or a workhouse, if suitable, to contain them; but if so housed it is essential that they should be controlled by the Board whose duty and object it is to supervise lunatics, and not be left under the charge of the Local Government which is in no way capable of their care, and which has never striven for their welfare and regards them chiefly as an incubus to be got rid of. In the Inspectors of Lunatics, on the other hand, we have an authority which has struggled with zeal, energy, and devotion for the amelioration of those committed to them, and which has achieved, since the appointment of the present holders of the office, a great improvement in all respects. Any further elaboration of this idea is in the present article inadmissible, but it may be as well to consider why Irish authorities insist on keeping lunatics in workhouses in face of much opposition on the grounds that they are neither suited nor adapted to it. The reason is easily found. It is a matter of fancied economy; the cost of maintenance is lower in workhouses than in asylums, so to save a shilling or two a week per capitem, the acutely insane often lose their chance of recovery, the paretic and demented are neglected, and the idiot occasionally pays the penalty of his life for the default of his guardians. And yet the difference of expense between doing a thing badly and doing it well would not be very great—a careful estimate made by the Mitchell Commission showed that an increase of 1d. in the £ on the valuation would enable all lunatics at present in workhouses to be placed in asylums. The apathy and indifference of the public on the subject has long endured, and is not likely to change, as neither party can make political capital out of the matter, and so the subject sinks into the abyss of neglect. But those who feel that suffering humanity is neglected, that by neglect much harm is done, that improvement could be easily attained, that the present condition of affairs is unjustifiable, are bound in honour and conscience to make a protest.

ON THE TREATMENT OF
FRACTURED PATELLA BY TRANSVERSE WIRING. (*a*)

By GEO. GIBSON HAMILTON, M.B.Ed., F.R.C.S.Eng.,

Surgeon to the Royal Infirmary, Liverpool, etc.

The speaker began by quoting the opinions of a number of surgeons as to propriety or otherwise of uniting simple fracture of the patella by the open method, the majority of these being, on the whole, adverse to the procedure as a routine. From statistics gathered three years ago, it seemed that of seventy-one English and foreign surgeons only nine advised operation, forty-one operated on selected cases, and twenty-one were against operation *in toto*. It would be admitted that suppuration was the only risk; but for this operation was unquestionably the best method of speedily and certainly restoring the usefulness of the limb. He had followed up the after histories, and secured skiagrams of the knee joints of a great number of cases, four, five and up to ten years after treatment by non-operative measures. In almost every case, even when the result was considered good, and a useful limb was possessed, there was marked separation of the two fragments. The whole question was one of a technique so satisfactory as to exclude the risk of infecting the joint; in cases of compound fracture he was in the habit of putting in large lateral drains, and trying as far as possible to prevent suppuration involving the synovial pouches. In performing the operation he was particular to allow no one except himself and an assistant to handle instruments. The skin and hands were prepared in the usual way. To remove hair he preferred the application of barium sulphide to shaving; it cleared off both hair and the roughened epithelium over the patella much more thoroughly than the razor. The incision was a transverse curved one, not too large, and not extending higher up than the middle of the upper fragment. Each fragment of the bone was then drilled from side to side by the mechanical drill, which was much preferable to the hand drill, by reason of its greater power; in consequence of the ease with which the holes were bored by it, there was no need for any great amount of manipulation of the fragments. A silver wire was then passed through the holes and screwed up at one side. The operation did not take longer than sixteen or seventeen minutes. He considered transverse wiring very much to be preferred to the ordinary vertical method. In the former the wire was well out of the way; in the latter the ends, when hoisted up, were just where the patient had to kneel upon, and were very apt to spring and give rise to discomfort. Another advantage of transverse wiring was that the fragments were got into more complete apposition, and that the joint cavity was thereby cut off from the superficial structure, so that infection was less likely to spread into it in compound fracture. In none of his cases had he met with infection; once there had been some inflammation round the stitch. The splints were removed about the tenth day; the patient was allowed up and began to move his leg on the fourteenth day, and by the end of a month it could be moved to a right angle. In the thirty cases of unoperated-on fracture which he had traced, no bony union was present in any one of them after ten years. The best results had been got by Malgaigné's hooks. In non-operated-on cases one could not but be struck by the frequency with which a second fracture took place. It must also be remembered that the non-operative treatment of fractured patella meant a period of from six to eighteen months, with, as he thought, an inferior result at the end of that time to what was got a month after wiring. One of the great benefits of operating was the removal from the joint of blood-clot, &c.; if this was got away, the exact method of dealing with the patella was of less moment, but it was leaving this that led to all the subsequent stiffness. For this reason, wiring was much more necessary in cases due to great violence, as in workmen falling from a height, &c., where the injury to the joint was considerable, than in other cases where it occurred after tripping on a stair, &c. In the former class, too, it was economically more important to get the patient back to work quickly, and with a thoroughly sound limb, than among the leisured classes. An important detail in the operation was to try to interfere as little as possible with the integrity of the para patellar ligaments, moving the bone laterally to the tibia.

(a) Abstract of Paper read before the Edinburgh Medico-Chirurgical Society, December 6th, 1905.

Transactions of Societies.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD DEC. 6TH, 1905.

DR. J. O. AFFLECK, President, in the Chair.

MR. C. W. **CATHCART** showed a case of congenital dislocation of the hip, after treatment, and (2) a case of patella twice sutured for fracture. Operative measures had been employed because of the great effusion into the joint after the accident; on the first occasion chromicised gut had been employed, but the patient fractured the patella a second time, so after a six months' interval it had required to be reunited. This time wiring had been performed, with a good result.

Dr. **BYROM BRAMWELL** showed (1) a man, æt. 50, who was admitted to hospital suffering from "pulsating abdominal aorta," and who was found to present a condition of multiple lipomata, the tumours being especially numerous on the forearms and thighs, though scarcely any region of the body was quite free from them. The tumours had been present as long as the patient could remember; they were quite painless, which differentiated the condition from Dercum's disease (adiposis dolorosa), and one which had been excised proved to be a pure lipoma, without admixture of fibrous or nervous tissue. The point of special interest in the case was its apparently hereditary character, the patient's mother, but no other ascendants or collaterals, having been similarly affected.

(2) "A Case of Ataxia" without any impairment of the sense of movement (muscular sense) in a man, æt. 60. There was no cause for the ataxia, which had improved considerably under a course of Frankel's exercises, but was still very marked. The gait, however, was not typically tabetic, but the legs were lifted more off the ground than in that disease, giving rise to a mixture of the stoppage and ataxic gait. The patient stood more steadily when the eyes were shut than might have been expected from the degree of ataxia. The remarkable feature, however, was that sensation was absolutely intact.

Mr. E. SCOTT **CARMICHAEL** showed a child, æt. 14 months, on whom he had operated for "Chronic Intestinal Obstruction." Ladder pattern was well marked, and on opening the abdomen a double stricture of the ileum near its entrance into the cæcum was found. A Paul's tube was inserted into the dilated small intestine, but as the child, though relieved by the operation, did not improve as regards its nutrition, Mr. Carmichael was driven, after about a fortnight, to reopen the abdomen, resect the cæcum, ascending colon, and four inches of small intestine along with some tuberculous glands in the vicinity, and perform an end to end anastomosis.

Mr. **DAVID WALLACE** showed (1) two patients after "Suprapubic Prostatectomy." In one there was also stone in the bladder; in both the prostate was comparatively small. In one case urine was not passed by the urethra till the twenty-sixth day; in the other it was passed naturally by the sixth day. The chief thing which influenced the date at which urine ceased to escape by the abdominal wound was the position of the openings through the muscle and bladder wall; when these were at different levels the urine ceased being voided by that route much more speedily than when they were at the same level.

(2) Malignant tumour of the colon removed by colectomy.

Mr. F. M. **CAIRD** showed (1) a patient after recovery from tetanus. On September 16th he had crushed his finger, which had been dressed at home; on October 3rd, he began to feel out of sorts, and on the 7th was admitted to hospital with abdominal pain. The abdomen was found to be hard and boardlike, the muscles of the neck were stiff, and there was slight risus sardonicus. The temperature began to rise and the symptoms increased for a week until the patient was so ill that his recovery was despaired of. The treatment consisted of large doses of antitoxin with various sedatives, and had been successful. (2) A patient after recovery from perforated duodenal ulcer. He also showed the results of a previous operation from coxa vara. (3) A woman in whom suture of a ruptured gastric ulcer had been followed by empyema and pneumonia, but who after a long illness of over 100 days, had recovered from the infection.

Dr. W. G. **AITCHISON ROBERTSON** demonstrated the "Uhlenbluth serum test" for the recognition of human blood. The serum is prepared by injecting a few centimetres of human blood into the abdominal cavity of a rabbit; after this has been done several times at intervals of a day or two the rabbits serum acquires the specific property of precipitating human blood, but not the blood of other animals. If, then, some of the serum be added to a dilute solution made from the suspected blood spot, a whitish precipitate speedily forms should the spot be human blood, but not if it is the blood of an animal. The medico-legal importance of such a test was obvious. In public health matters, also, a serum prepared in the same way from horses' blood could be used to detect horseflesh when mixed with beef.

The following specimens were exhibited:—

By Dr. W. T. **RITCHIE**, micrococcus catarrhales from case of bronchitis.

By Drs. **BRUCE**, **McDONALD**, and **PIRIE**, sections and photographs of a localised duplication of the cord.

By Mr. **CATHCART**, miliary tuberculosis secondary to tubercle of the kidney.

By Mr. E. SCOTT **CARMICHAEL**, tuberculous stricture of ileum; vesical calculus from a boy, æt. 3.

By Mr. **WALLACE**, two prostates enucleated through suprapubic route.

By Mr. **CAIRD**, Intracranial abscess; the symptoms pointed to the arm centre being involved, whereas the lesion was actually below the centre for the leg.

By Mr. **THOMSON**, a tuberculous kidney, removed by lumbar route, which excreted no indigo-carmine and admitted of functional diagnosis both with cystoscope and separator.

By Dr. A. N. S. **CARMICHAEL**, organs from a case of blackwater fever.

Mr. GEO. G. **HAMILTON** (Liverpool) read a paper, with a lantern demonstration, on "The Treatment of Fractured Patella by Transverse Wiring," an abstract of which will be found under the heading of "Original Communications."

The paper was discussed by Mr. **CATHCART**, who said that ability to open the knee joint was always regarded as a criterion of a surgeon's aseptic technique. On thinking over the reason why infection was so much more liable to occur in a joint than in the peritoneal cavity it seemed to him that, besides the great power which the peritoneum had of dealing with bacteria, there was the fact that in the knee the effusion was fluid, not lymph. Hence there was never any shutting off of inflammation, which speedily spread all through the synovial cavity. A useful limb might be got well more by fibrous union; he knew an excellent athlete who had held the record for the high jump who had an inch of separation.

Mr. **CAIRD** thought that Dr. Hamilton's results more than justified him in operative interference. He did not, however, think that it could ever become a routine practice, on account of the risks involved. Disaster meant the loss of the limb, if not of the patient's life. Logically, if perfect aseptic technique could be assured for the knee-joint, it would follow that every simple fracture should be wired—as had indeed been advised by some American surgeons. But unfortunately in wiring fractured patella, joint infection had taken place even with the most skilled surgeons, and the risk of a serious mishap could not be entirely eliminated.

Mr. **ALEXIS THOMSON** thought that, although by non-operative measures it was rare to get bony union, still it was unfair to regard cases with merely fibrous union as failures. The criterion, after all, was the usefulness of the limb, and he had seen most favourable results even in cases which seemed most unlikely to do well, by ordinary treatment. Too little attention was paid to the lower fragment; if it was controlled by a strip of plaster a good union would be obtained even if the upper fragment were left alone.

Mr. **Hamilton**, in reply, said that he emphasised the need for wiring especially in working men to whom as speedy a return to work as possible was a desideratum. Again, a limb good enough for ordinary purposes might not be good enough to allow of a man resuming a dangerous employment. His cases, he thought, were on the whole more severe than those commonly referred to by the speakers, probably because in Liverpool dock accidents, &c., were commoner than in Edinburgh.

Dr. **William Russell** read a paper on "The relations of Angina Pectoris and allied conditions to a vasculo cardiac reflex, having its origin in the abdomen." We hope to publish a full abstract of this paper in our next issue.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Pathology.

Meeting held Friday, November 24th, 1905.

The President, Dr. **Joseph O'Carroll**, in the Chair.

ANEURYSM OF AORTA.

The President and Dr. **Earl** showed an aneurysm which came off the aorta a little above the aortic valve. It lay between the aortic arch and the base of the heart, and pressed on and flattened the pulmonary artery. There was hypertrophy and dilatation of both chambers of the right side of the heart.

Professor **McWeeney** called attention to the fact that it had recently been found possible to produce aneurysms in animals experimentally by the continual injection of extract of suprarenal capsule; therefore, it would appear that one of the pathological factors in the production of aneurysm would be some toxin, with a capacity for raising the arterial pressure.

LYMPHOSARCOMA OF THE MEDIASTINUM.

Mr. **Seton Pringle** showed a specimen of lymphosarcoma of the mediastinum. The patient, a man, æt. 30, had for eight weeks before death presented the following signs and symptoms:—A firm œdematous swelling of the upper thorax, head and neck more marked on the right side, greatly distended veins on the arms, dyspnœa, dysphagia, cyanosis, and an area of dulness behind the manubrium and upper part of gladiolus sterni, and extending two inches beyond the right sternal margin. All these signs gradually increased in severity, and a left pleural effusion developed some days before death. At the *post-mortem* the growth was found extending from the arch of the aorta to the upper border of the sternum; it also extended back on either side of the trachea, and on the left side pressed on the œsophagus, while the right lung was extensively infiltrated, and adherent to the growth above the root. Mr. Pringle called attention to (1) the very rapid growth; (2) the fact that the pulse was equal and synchronous in both radials although the innominate artery was embedded in the growth, and the left subclavian free; and (3) the presence of recent pleuritic adhesions on the right side, that is, the side on which the lung was involved.

The **President** spoke, and Mr. **Pringle** replied.

LYMPHOSARCOMA.

Dr. T. G. **Moorhead** exhibited a lymphosarcoma of the anterior mediastinum. The patient from whom the specimen was obtained had first noticed an enlargement of the glands in her groin, neck, and axillæ two years previously. When first seen in May, 1905, she presented the typical appearance of Hodgkin's disease, except that there was no splenic tumour. The leucocytes were reduced to 3,000 per cm., and showed a relative excess of eosinophiles and hyaline cells. When seen again in August, 1905, her condition was unchanged, but twenty days later she returned with the glands swollen to five or six times their former size, and with distinct evidence of thoracic involvement. At the *post-mortem* a typical lymphosarcoma was found in the thymic region, and most of the cervical and axillary glands had extended beyond their capsule. Dr. Moorhead expressed the opinion that the case was what is generally regarded as acute Hodgkin's disease, and stated his belief that that process was identical with lymphosarcoma.

Dr. **Travers Smith** asked was there any relative lymphocytosis, and was the spleen palpably enlarged when the patient first came under Dr. Moorhead's notice?

Dr. **Moorhead** said he had only noticed very big hyaline cells, especially towards the end of the case. He thought these were common in the condition. The spleen was at no time enlarged to palpation. An early blood-count showed—neutrophiles, 68 per cent.; eosinophiles, 6 per cent.; lymphocytes, 17 per cent.; hyaline, 9 per cent. In August the eosinophiles were 5 per cent., and hyaline 9·5 per cent. The total number of leucocytes was from three to four thousand throughout.

UNUSUAL TUMOUR OF KIDNEY.

Mr. C. **Arthur Ball** showed a renal tumour removed by nephrectomy from a young married woman, æt. 23. He stated that the tumour was first noticed, by the patient herself, five days after her confinement, as a small lump which she could move about in the left side of her abdomen. The patient said nothing about the tumour until its rapid increase in size began to alarm her. It was removed exactly seven weeks after it was first noticed as a small lump; the kidney, which weighed exactly three pounds, was very adherent, and surrounded by large blood-vessels; the patient made an excellent recovery. Previous to operation, cystoscopic examination and segregation of the urine from each kidney established the fact that the left kidney (the side of the tumour) was not functionating. Mr. Ball stated that it was a point of considerable interest that a solid tumour of the kidney could grow so rapidly, and asked for information as to whether the tumour was likely to recur either locally or by metastases. The patient never had hæmaturia, and the urine was quite normal.

Professor **O'Sullivan** said the tumour was an encapsuled lobulated growth lying in the enlarged pelvis of the kidney, which it completely filled. The kidney and tumour were enclosed in a single capsule, the kidney lying above the tumour. There was a good deal of necrosis, with hæmorrhage into the necrosed tissue. The microscopic appearances were various, showing, in different parts, papillæ covered by cubical epithelium, spaces lined by a similar epithelium, some invaded by papillæ and irregular masses of epithelium, with a few strands of hyaline connective tissue separating them.

Professor **McWeeney** did not think the fact of the tumour lying underneath the kidney was against its being of suprarenal origin, as the great majority of these tumours had been found starting from the pelvis of the kidney. He pointed out that what was described by Professor O'Sullivan as delicate connective tissue papillæ, with cubical epithelial cells on each side, was precisely the structure that was found in suprarenal tissue tumours. He asked if Professor O'Sullivan had tested for glycogen, as it was supposed to be found in a large majority of these cases.

Professor **O'Sullivan** said he had not examined for glycogen, but would do so. The appearance of the cells was so unlike that of suprarenal cells, or even what he remembered of those in the tumour Professor McWeeney himself had shown, that he could not believe it was of suprarenal origin.

Dr. **Earl** said he had seen a tumour which resembled the one before them very largely in its histology, but naked-eye appearances were different. It was much softer, almost diffluent. Sections from different parts of it differed very largely. He did not form any opinion as to its origin, but could not persuade himself that it was suprarenal.

Mr. **Gunn** described a case in which the clinical history was somewhat similar to that of Dr. Ball's case.

Mr. Ball replied.

MELANURIA.

Dr. T. G. Moorhead exhibited the organs of a patient who, during life, had presented the symptoms of melanuria. The patient was a woman, æt. 30, who had suffered from an orbital tumour for seven years, and had frequently been urged to have the eyeball enucleated. She had refused operation, however, until August, 1905, when, on account of its unsightly appearance, she had submitted to removal of the eye. In September, 1905, she was admitted to the City of Dublin Hospital suffering from enlargement of the abdomen and from breathlessness. The liver was found to be enlarged, and to be studded all over with nodules, and there was considerable ascites. The urine was of a light brown colour when passed, but rapidly darkened on standing, and ultimately became almost quite black. It gave a typical black colour, with perchloride of iron (von Jaksch test), and was also darkened by strong acids. There was no indican, no sugar, and no blood present. Neither the ascitic fluid nor the blood gave the melanin reaction. *Post-mortem*—The liver was found enormously enlarged, weighing 13¼ pounds, and was extensively infiltrated with melanotic growths of various sizes. Similar tumours were found in most of the other viscera, and both ovaries had become converted into large unilocular cysts with melanotic walls.

Dr. Mooney said he had the original tumour. It occupied the orbit, and was the blackest tumour he had ever seen. The sclerotic was invaded, and, after removal of the eye, the remaining tissues were still infiltrated with black pigment.

Drs. Travers Smith and Professors O'Sullivan and McWeeney, having remarked on the unusual characteristics of the case,

Dr. Moorhead, in replying, said that he had tried the bromine water test, but it gave a black precipitate, just like the others. There were no cutaneous lesions. He thought that von Jaksch's was now admitted to be the best test. In reference to Nylander's test, he said he had repeated both it and the copper test on two or three occasions. He got a slight reduction with copper, but only on prolonged boiling, but Nylander's test came out unusually quickly. He did the phenyl hydrazin test, and did not get any characteristic crystals.

OTOLOGICAL SOCIETY OF THE UNITED KINGDOM.

First meeting of the Session held Dec. 4th, 1905. The President (**Dr. Thomas Barr**) delivered his valedictory address, in which reference was made to the increasing prosperity of the Society and to the growing field for research in otology.

Mr. Cheatle read a short paper on the

PREVENTION OF EAR AFFECTIONS

due to exposure to loud noises and to explosives. The conditions referred to were those affecting boiler makers, soldiers, sportsmen, and, specially, naval men. It was pointed out that the ear affections produced by gun fire in the Navy were worthy of the serious attention of the authorities. The conditions met with were rupture of the membrane, nerve deafness from a single concussion, and nerve deafness coming on gradually.

Messrs. Tilley, Baker, Milligan, Mole, Law, Macleod Yearsley, Pritchard, Dundas Grant, Fagge, Cumberbatch, Jackson, and the President took part in the discussion.

Specimens and cases were shown by Messrs. Macleod Yearsley, R. Lake, Kerr Love, Mole, Bronner and Kelson.

The following members were elected as officers and Members of Council for the ensuing Session, 1905-1906: *President.*—Alphoun Elkin Cumberbatch *Vice-Presidents*—Charles A. Ballance, Adolph Bronner, and Robert Henry Woods; *Honorary Treasurer*—Edward Law; *Honorary Librarian*—Richard Lake; *Honorary Editor of "Transactions"*—Walter Jobson Horne; *Council*—Thomas Barr, Logan Turner, Frederick William Bennett, William Permewan, Laurie Asher Lawrence, Charles Herbert Fagge. *Hon. Secretaries*—Macleod Yearsley, Henry Secker Walker.

The annual dinner was held on the evening of the same day.

LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD DECEMBER 1ST, 1905.

The President, Mr. **Charters Symonds**, in the Chair.

Dr. Watson Williams showed an excellent specimen of a Rhinolith.

Mr. Barwell brought two cases of ulceration of the nose in a phthisical patient, which had healed under treatment, and a case of lupus of the larynx and uvula, which also had undergone cure.

Mr. De Santi showed a patient on whom thyrotomy had been performed for laryngeal stenosis.

Dr. Brown Kelly showed a case of sclerotic hyperplasia of the pharynx and naso-pharynx in a man, and two admirable sketches of multiple telangiectasis of the skin and mucous membrane of the nose and mouth.

Dr. Peters exhibited a girl with a polypus attached to an unusually elongated uvula.

Other cases were shown by Drs. Grant, Cathcart, and William Hill.

Dr. E. Law reported the fatal termination of the case of a girl, shown at a previous meeting, with incrustation of the trachea and well-marked stenosis, she having suddenly choked while kneeling.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD NOV. 30TH, 1905.

Dr. G. C. **Walker**, Vice-President, in the Chair.

Dr. J. Lloyd Roberts showed two cases of "Friedreich's Ataxia," occurring in a brother and sister, æt. respectively 16 and 23. The patients were two of a family of seven children, the girl being the third and the boy the fifth child. The remaining children were healthy, and no relatives, so far as could be ascertained, had ever suffered from any disease similar to theirs. The parents were alive and healthy; there was no blood-relationship between them. In both cases the symptoms of ataxia were pronounced, being more marked in the girl, in whom the symptoms had been noticed six years ago; the weakness and ataxia first appearing in the upper limbs. She was now scarcely able to walk without assistance, and her speech was markedly affected.

Dr. W. H. Broad read a note upon "Massage and Exercise Treatment." After mentioning the various methods employed—manual, mechanical and massage—he described several of Dr. Zander's "exercise machines," saying he had obtained the greatest possible benefit from a combination of mechanical and manual exercises. A *résumé* of six months' hospital work was given, during which period there had been 1,071 attendances, including cases of scoliosis, wry-neck, flat foot, stiff joints, ruptured muscles, rheumatoid arthritis, &c.

Dr. Hubert Armstrong read a note on a possible danger in "Exploratory Puncture of the Chest." He illustrated his remarks by the case of a girl, æt. 2 years and 9 months, whose chest he had explored with the view of excluding empyema, the physical signs being those of chronic interstitial pneumonia. The puncture was followed by hæmoptysis and sudden alarming collapse, from which the patient, unlike others which were cited from recent literature, recovered. Dr. Armstrong drew attention to the danger of syncope, especially in children, when the needle entered a lung in a state of chronic inflammation, and added some remarks upon the pathology and treatment of this distressing, if rare, accident.

Mr. W. Thelwall Thomas read a paper on

INTERNAL DERANGEMENT OF THE KNEE-JOINT,

including in that phrase all the conditions which cause "locking" of the joint. These were classified as follows: (1) Fracture and displacement semi-lunar cartilages; (2) fracture of portions of the femoral condyles; (3) loose bodies; (4) synovial fringes; (5) other rare conditions. After considering the movements of the knee-joint, the causes and accidents which led to "locking" were described. In a series of 44 cases the semilunar cartilages were found at fault in 28, the internal cartilage being damaged in 25, the external cartilage in 3. Of the internal cartilage longitudinal fracture partial or complete was found in 18 cases, total separation of the circumference in 1 case, partial separation of the anterior third in 6 cases. Of the external semilunar cartilage (3 cases), separation of the anterior third was seen. In no case was the fibrous extremity of either cartilage damaged. Three cases of fracture of the femoral condyles were described. The differential diagnosis of these several lesions was considered at some length. Treatment was discussed under the headings "Palliative" and "Radical." In the treatment of the initial synovitis, Mr. Thomas insisted upon absolute rest, with the application of a posterior splint specially padded at the popliteal space, together with firm pressure over the knee. He urged the uselessness of continuing with supports of any kind when recurrent locking took place, and strongly advocated operation when the occupation of the patient demanded much strain upon the joint. At the operation he always removed the offending portion of the semilunar cartilage or fringe, and allowed movement of the joint ten days later. The material used for suturing the synovial membrane and capsule of the joint was chromicised reindeer tendon.

Mr. **Rushton Parker** agreed that stitching of the damaged cartilage was seldom practicable, and when so not worth while. He had only done so in one case; in all the rest he had cut the torn portion away.

Mr. **Robert Jones** stated he had operated upon 23 cases this year. In two the injury was to the external, and in 21 to the internal cartilage. When the protrusion could be felt from the outside, it favoured the diagnosis of displaced synovial fringe rather than damaged cartilage.

Mr. Damer Harrisson, Mr. George G. Hamilton, Mr. G. P. Newbolt, and Mr. E. M. Stockdale also took part in the discussion.

Special Article.

LUNACY IN NEW ZEALAND.

The Annual Report of the Inspector-General of Mental Hospitals in New Zealand for the year 1904 has recently reached us, and contains certain important statistics, together with interesting comments thereon. We are glad to note in the first place that the term "asylum," with all its sinister associations is given up, and the more cheerful term "mental hospital" adopted. The change is a good one, since it emphasises the fact that an institution so designated is one for curative treatment, and not merely for the massing together of large numbers of diseased persons.

There are eight of these hospitals in New Zealand, and on December 31st last they contained in all 3,088 persons, 1,801 males and 1,237 females. It is instructive that the incidence of mental disease is less among the Maoris than among the other races in New Zealand, suggesting either that the Maoris are a very sane race, or that the conditions of modern civilisation are not conducive to sanity of mind. The proportion of the total insane to the total population is 1 in 296, while if Maoris be excluded it is 1 in 285. The Inspector-General takes the correct "official" view of what he calls "the alleged increase of insanity in the colony," and he attempts to show, by a rather confusing mass of figures, that the increase is apparent, not real. The fact remains, however, that each quinquennial period during the past thirty years shows an increase on the preceding period in the rate of insanity, and that individual years, if compared, show proportional increase. This steady increase is, moreover, nearly as marked in recent years as in the earlier. The Inspector-General admits, however, that "it is vain to deny that with our selected population, our general evenly distributed prosperity, and less strenuous life, there is too high a proportion of mental disorder in the community." He shows, too, that he recognises that statesmanlike dealing with the problem of insanity is not a mere matter of mental hospitals:—

"The intelligent consideration of this complex problem does not begin with—nay, it ends with—the establishment of mental hospitals, which are, in truth, the monuments of failure. It should begin with prophylaxis, and prophylaxis should begin before birth. It would be too great an interference with the liberty of the subject to forbid the marriage of unsuitable persons; and to preach the doctrine of heredity and stress is to speak to the deaf; but with a State insurance system (suggestive of that which obtains in Germany, though wider in scope), one may, on the principle that the issue of such unions may become chargeable to the State, fix a proportionately higher premium, and thus enlighten the contracting parties by the most forceful of arguments.

"Prominence has been given recently to questions affecting infant death-rate, and the initiation of the training of midwives and maternity nurses to work among the humbler and the less informed, should be productive of incalculable good. They will be the missionaries of the gospel of proper feeding, of fresh air, and of cleanliness.

"The next important period is the school age. Of the highest importance to the future of the State is the physical and mental well-being of school-children. They should be scientifically classified according to their abilities and disabilities; and when the time comes for such knowledge should be taught to intelligently understand why Nature is unmerciful when her laws are violated.

"Thereafter failure would not be so frequent, and would be the fault of the individual, not the State. All of which is summed up in the direct simplicity of the old proverb, 'Prevention is better than cure.'"

Strong arguments are put forward urging the necessity of keeping the criminal insane apart from other insane patients, and of entirely dissociating the magisterial examination of an alleged lunatic from other magisterial functions.

The percentage of deaths on the average number resident during the year was 6·38. Of the total number of deaths (190), phthisis is returned as the cause in 13. In many of the hospitals suitable provision is made for tuberculous patients.

Classification of the causes of insanity is everywhere notoriously difficult, so that the comparison of tables made by different observers is of little value. The present returns, however, show that of 580 admissions, alcohol is held accountable in 66 cases, and congenital and hereditary conditions in 106.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, December 10th, 1905.

Treatment of Syphilis.

There is no particular method of mercurial treatment to the exclusion of others, for all cases and for all periods of syphilis. Treatment by injection, intramuscular injections or frictions has each its special indications, advantages, and disadvantages, says Dr. Bouveyrou.

Friction is the old treatment, but exposes to stomatitis, because it is frequently ill applied and its effect depends upon a host of conditions of a physical or other order.

In any case the friction should be done at bedtime, and practised for 20 minutes and on a limited portion of the skin. The first evening the patient should rub the ointment on both legs, the second on both thighs, the third on the abdomen, the fourth on the back, the fifth on both arms; after which the series is recommenced in the same order. The morning after each friction, the region should be washed with soap and hot water. Not more than a drachm of mercurial ointment should be employed each time.

Mercurial frictions are specially indicated in the treatment of hereditary syphilis of infants, for at this age the danger of stomatitis is absent and the renal organs are very active. About 15 grains of the ointment should be rubbed on the back daily.

Intra-muscular injections of the soluble or insoluble salts of mercury will constitute an exceptional treatment of syphilis, and are indicated when it is necessary to obtain a rapid and intensive action on the disease, as for instance in cerebral or medullary complications. The soluble salts should be employed where hepatic or renal insufficiency is observed.

The majority of the soluble injections are more or less painful, yet the lactate and benzoate of mercury and hermophenyl are less painful than the bi-iodide or corrosive sublimate. Frequently the pain radiates along the tract of the sciatic nerve and for that reason the region of the large nerve trunks should be avoided. The needle should be planted in the upper third of the buttock or in the centre of a line running from upper extremity of the cleft to the anterior superior iliac spine. Generally the injections are made alternately right and left. It matters little if a portion of the injection enters a vein, for soluble injections are never followed by embolus.

Lactate, benzoate, and bi-iodide of mercury are employed at the daily dose of ⅓ grain, and should be sufficiently diluted (2 cubic centimetres or 33 drops of water).

Salicylarsinate of mercury and hermophenyl are generally but little painful in injections, and are given in larger doses than the preceding (½ to 1 grain). Hermophenyl may be employed at larger dose (1¼ gr.), but only as a *weekly* injection.

Daily soluble injections are more rapid in their action and more beneficial than the same doses given by the mouth. They are speedily indicated in grave lesions, or in lesions of an important organ.

The insoluble injections are made with grey oil, calomel, or proto-iodide of mercury.

The grey oil possesses great advantages and some disadvantages. Among the former may be mentioned the fact that it is but slightly painful, and that it does not lead very much to the formation of emboli, on account of the small quantity injected. The disadvantage is that a special instrument is necessary. In order to inject dose properly, Barthelemy's syringe must be employed.

The piston of this syringe marks 15 divisions, of which each one corresponds to ⅙th of a grain of metallic mercury. About seven of these divisions are injected each time, and renewed once a week. After a series of six or eight injections, the patient should be allowed a rest of fifteen days. If calomel be employed the vehicle should be ordinary syrup of sugar, and not olive oil or vaseline, which favour the production of emboli, the great danger of injections of insoluble salts.

The formula might be as follows:—

Calomel, 7 grains.
Syrup of sugar, 2½ drachms.

One or two syringes (Pravaz) to be injected once a week.

The majority of these insoluble injections are more or less painful, those of calomel particularly so, obliging frequently the patient to keep in bed, for the pain lasts three or four days; these injections sometimes also provoke abscesses, or subcutaneous nodules, which are very painful and this occurs generally where the injection had not been made into the muscular mass, but rather subcutaneously. The urine should receive particular attention, as albuminuria appears frequently as a result of mercurial injection, especially those of the soluble salts.

As to the internal treatment of syphilis, the soluble mercurial salts should be preferred to the insoluble salts of calomel or tannate, as their absorption are very irregular and expose the patient to stomatitis. Among the former may be mentioned corrosive sublimate, lactate, and bi-iodide of mercury. Corrosive sublimate is an excellent preparation, but irritating to the stomach. It is given in pills at the dose 1–13 of a grain three or four times a day, associated with a similar dose of extract of opium. The bi-iodide of mercury is very irritating to the stomach, and should not be prescribed.

The best preparation is the lactate which is very soluble and almost tasteless and for that reason can be administered in solution (1–1,000). A tablespoonful twice a day at meals. A good form also is that of pastilles at the dose of 1–13 of a grain of lactate in each, nine of these lozenges may be taken daily. They are particularly effective in the secondary stage of the malady, where mucous patches are observed in the mouth and on the tonsils, constituting an excellent local treatment.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, December 10th, 1905.

AT the Free Society of Surgeons, Hr. Brentano spoke on

GUNSHOT WOUNDS OF JOINTS.

As Surgeon-in-Chief of the German Red Cross Hospital in the Russo-Japanese War, he had treated a total of 350 surgical cases; 150 of these resulted from the battle of Mukden, and the patients were admitted into hospital in a miserable condition. For this reason they were to be considered a class apart from the rest of the wounded; 19 of them died in consequence of infection they brought with them into hospital. The injuries were caused by small calibre bullets, shrapnels, and some especially heavy hand-grenades, but no wounds from large splinters of grenades were met with. Twenty-eight cases of joint injury were treated, 12 of which were infected on admission. All joints both of upper and lower extremities were affected. The entrance and exit openings were small, there was but little splintering, and extensive laceration of soft parts with smashing up of bone was present in only one case. It was a wound of the wrist caused by the near explosion of the frightfully destructive hand-grenade. In spite of the extensive damage the wound healed aseptically, but resection had to be performed later, as the splinters of bone did not unite. In the other cases the diagnosis of joint injury was arrived at from the situation and direction of the shot, the pain in the joint on movement, the effusion of blood into the joint, and the saturation of the dressings with articular fluid.

The treatment of the non-infected cases consisted in the application of an aseptic dressing, and the fixation of the joint in plaster of Paris. Later on, but not too soon, massage and passive movement were made use of. Power of movement was not quite recovered in some cases. Operative measures were adopted only in cases of near shots and considerable destruction of the joints as well as for the secondary removal of the projectile.

In the twelve cases of infected wounds, the infection was in direct proportion to the extent of injury to soft parts and destruction of bone. Where immediate amputation was not necessary, extensive incisions were made into the joint, but for the hip-joint these were not sufficient; here resection was indispensable in order to provide an exit for the pus. The fever did not cease at once after an opening, but one should not decide on amputation too soon. Fixation of the joint in palm leaves, with openings out into them, and strengthened by plaster of Paris, frequently led to a desirable termination. High amputation had only to be carried out in one case, in which an infected wound of the elbow, hand, and forearm began to mortify; the patient died of tetanus in spite of the amputation. This was the only fatal one amongst all the cases of joint injury.

Exc. v. Bergmann regarded what had been said as a proof of the correctness of his views, viz., that primary infection of wounds, *i.e.*, from the object causing the wound, was rare. The presence of a foreign body in the wound was not a sufficient ground for operating with the object of removing it, as it would often become aseptically embedded without causing the slightest disturbance.

Hr. v. Dettingen, who was part of the time near the firing line, objected to the general use of the plaster of Paris dressing. Most of the surgeons were not masters of it sufficiently, and a plaster of Paris dressing badly put on was worse than none at all or splints. True to the teaching of v. Bergmann, he had tried not to individualise, but to follow a plan, and he had made it a rule in cases of injury to the knee, which were the more frequent of all joint injuries, to apply a pasteboard splint at once. If infection had taken place, it was to be ascertained whether the patella was wounded or not. If not, free incisions were to be made into the joint, and if the temperature did not fall within twenty-four hours the patella was to be sawn through and laid back, and if this was not enough it was to be resected. If the patella was splintered and the splinters were removed, and this was found to be insufficient, resection was to be performed at once. He had had good results in following this line of procedure.

Hr. Körte spoke on

Surgery of the Stomach.

He said that when gastroenterostomies and similar operations had not been followed by very satisfactory results in case of callous circular ulcer of the stomach, a number of operators had proceeded to extirpate the ulcer. It was to be borne in mind that such operations were always very difficult and atypical. The separation of the base of the ulcer from the liver was comparatively easy, more difficult, however, from the pancreas, and here the danger of hæmorrhage was very great. Difficulties might further occur in uniting the edges of the ulcer after resection, and for the accomplishment of this it was always necessary to put in tentative stitches at once. A young girl was shown who had happily recovered from such an operation. The future must show whether such patients remained free from recurrence. Such operations would only be permissible if such proved to be the case; otherwise they would not be justifiable.

In another patient the ulcer extended to the duodenum. Here, after the method proposed by v. Eiselsberg, he separated the stomach above the diseased pylorus, inverted both ends, and closed in the gastroenterostomy.

The following case was a contribution to the question as to whether dilatation of the stomach occurred without stenosis of the pylorus. A single woman, æt. 40, had been under treatment for years, but her trouble from dilatation of the stomach gradually increased. On opening the abdomen, an enormous dilatation was found, along with gastroptosis. The pylorus was carefully examined both from without and within, but no changes were found. The low-lying greater curvature pulled originally on the pylorus, tightened it, more so as it sank lower.

In another case, in 1902, retro-colic gastro-enterostomy was done for obstinate symptoms of ulcer. The patient improved, but got much worse again after extirpation of the appendix. When laparotomy was again performed, the pylorus was so much displaced that it would not admit the finger. In the neighbourhood of the gastro-intestinal fistula there were extensive adhesions (a new ulcer?). Anterior gastroenterostomy was now performed with subsequent improvement of the patient's condition.

Hr. Körte then mentioned three cases of resection of the stomach for carcinoma and showed two patients and a preparation. He also showed two patients who had suffered from acute inflammation of the pancreas, and had been operated on successfully. In both cases the cause of the inflammation was biliary calculi, but only one had suffered from biliary colic. The operation consisted simply in letting out the exudation.

Austria.

[From our own Correspondent.]

Vienna, December 10th, 1906.

Bier's Treatment of Acute Inflammation.

At the last meeting of the Gesellschaft der Aertze, Ranzi demonstrated how he treated acute inflammation by means of his congesting and suction apparatus according to Bier's method of treatment. Cases reported on from Eiselsberg's ward proved the efficacy of the treatment.

Volk added his meed of praise to the virtues of this method in the treatment of venereal diseases, particularly the bubo and soft chancre.

Jerusalem extolled its use in club practice.

Frankl gave the members his experience of the treatment in gynæcological cases which he had carried out with the assistance of Rudolph's apparatus, which was principally in the form of suction. The portio was made hyperæmic, which eventually exuded large quantities of mucus and blood, as seen by the speculum. It was in the sclerotic form of chronic metritis and amenorrhœa that the greatest good could be obtained from this form of treatment.

Moorhof was quite prepared to admit the favourable results obtained, more particularly in phlegmonous inflammations, but confessed that it was a failure in gonorrhœic arthritis. He related the frequent failures which he had had in former years, and the recent successes in caries of the joints since he commenced with the congestive treatment.

Ullmann had practised Bier's treatment in dermatology with success, as well as inflammatory conditions of the pars anterior urethra, gonorrhœa, post gonorrhœa, and tuberculous infiltration of the testes.

Weinlechner said that the congestive treatment in tuberculosis was slow, but in no way injurious. Eiselsberg had practised this treatment in several cases of tuberculosis in the bones and joints with the best results, but never met with any subsequent injurious effects.

A Double Aneurysm on Aorta.

At the Gesellschaft, Klein showed specimens of aneurysm taken from a young man, æt. 30, who shortly before death had suffered from an attack of influenza that left bronchitis followed by dyspnœa, paresis of the right vocal cord, cyanosis, and œdema of the right arm. Tracheotomy was performed to relieve the dyspnœa, which it did to a great extent. The pulse pressure in the right radial was somewhat lower than the left. The Röntgen rays revealed a shadow immediately above the bifurcation of the trachea. The tracheoscope showed the right bronchus quite closed.

The clinical diagnosis was somewhat obscure, but the *post-mortem* soon cleared up the doubt by revealing two large aneurysms on the aorta which had pressed firmly on the trachea and right bronchus; the thrombus by its constant pressure on the wall of the bronchus had produced a parietal perforation.

The peculiarity of this case was the absence of any previous clinical symptoms and the perfect absence of hæmoptysis, although there was a distinct opening into the trachea.

Grossmann related the history of another peculiar case where no information could be got from the clinical history, radiology, or careful observation beyond the dyspnœa and a fistula between the right bronchus and œsophagus, or a tracheal fistula through which the tube of the stomach pump passed.

One day this tube would not pass for some reason or other, and the patient suddenly died from suffocation.

The *post-mortem* revealed an acute pneumothorax probably caused by the insertion of the instrument.

Bier's Treatment in Testitis.

Ullmann showed three cases treated by Bier's congestive method by means of a broad elastic band four centimetres, or 1·58 inch, in width. The treatment was commenced with a half or an hour daily; the band being applied tightly over penis, scrotum, and genitals, where it was retained until cyanosis appeared; after which the parts were relieved till they resumed a bright red tint, when the band was re-applied.

The longer the band can be applied the more effectual the treatment, but care is necessary not to damage any of the structures although the pain of congestion will always be a good guide. When no pain or swelling is present the treatment is a simple matter.

When the spermatic cord is almost normal, the scrotum not distended, or the tumour not attached above a narrower elastic band may be used, not exceeding three centimetres, and directly applied at the root of the penis above the tumour. Where the tension required is moderate and no special circumstances to be considered, the proper method to pursue is to bind up the entire genitals with the broad elastic band.

The hyperæmic method is the converse of the congestive, and must be applied in the form of warm water or hot air extending necessarily over a wide cutaneous area. This wide surface is also involved in the congestive form as well, which may be the fundamental principle of the cure, whereby a larger quantity of blood is brought into the tissue to increase its nutrition.

Bum expressed a desire to correct himself in the technique of this treatment, which he omitted at the last meeting. He wished it understood that an intense pressure on the arteries, which Bier called "cold congestion," was not necessary. The compression of the veins for twenty-four hours at a time was sufficient to produce the desired effect.

Bauer showed his improved apparatus at the end of the discussion, which resembles a speculum with a tube for extracting the air or depressing it according to the desire of the surgeon, thus relieving him from laborious fastenings and failures, leaving the surroundings free for observation.

The Operating Theatres.

ST. THOMAS' HOSPITAL.

Extirpation of the Penis.—Mr. Battle operated on a man, æt. 44, who had been admitted a few days previously for an ulceration of the penis. It appeared that he had had a sore place under the prepuce with a discharge for some months and for the last two months he had been under treatment by a chemist, who had promised to cure him; but in consequence of the gradual extension of the disease the patient at last decided to apply at St. Thomas's for further advice. On admission there was a hard sore under the prepuce which was exposed by slitting up the foreskin. It was situated along the line of the corona glandis and had eaten considerably into the glans. Higher up on the left side of the penis there was a fluctuating swelling which when incised, gave exit to broken down material and pus, the cavity being evidently broken down sloughy growth. The lymphatics at the root of the penis were enlarged and indurated, and the glands in both groins were also enlarged and indurated, being also rather adherent. The pelvic glands could not be felt to be enlarged. A portion of the growth from the end of the penis was removed for microscopical examination, which showed it to be epithelioma. The patient's left knee was enlarged and contained fluid, whilst the synovial membrane was irregularly thickened; over the front of the right knee there was a serpiginous eruption, with brown markings. The general condition of the patient was fairly good. It was quite evident that nothing short of complete extirpation could give him even temporary relief; accordingly, this operation was performed. An incision was carried through the middle line of the scrotum and the urethra exposed; this last was divided about three inches in front of the anal margin and turned downwards; the incision was carried upwards and round the root of the penis, so as to include the distended lymphatics which appeared close to it; the suspensory ligament was divided and the crus penis separated on each side with the help of a raspatory. Hæmorrhage having been arrested the upper surface of the urethra was slit for half-an-inch and its extremity sutured to the middle line of the scrotum behind. Stitches were then inserted closing the posterior part of the incision almost completely. It was decided to remove the glands from both groins; this involved removal of the overlying skin, as the glands were adherent to it and a rather troubleseome dissection on both sides in the neighbourhood of the saphenous opening. When this had been completed, as the incisions had been prolonged to the middle line to enclose the diseased lymphatics between the glands and the penis, a very large wound resulted which required some time to close with fish-gut sutures. The upper part of the main wound was brought together at the same time and so more skin secured to close in the exposed fascia. Drainage tubes were used in each groin and one from the pubes to the lower part of the wound. Perchloride of mercury 1 in 1,000 was employed as the antiseptic. The patient's thighs were flexed on the trunk to relax the parts and cyanide gauze dressings applied. Mr. Battle said this was one of the most extensive cases of epithelioma of this part he had come across, the growth on all the body of the penis being very large. The case, he thought, was a very instructive one from the point of view of diagnosis, for here was a man with a malignant sore on his penis which was being treated as a hard chancre by a person who was not able to appreciate, even if he knew of, the conditions of the knees. There was no doubt that the patient had tertiary disease both of the synovial membrane of the left knee and of the skin over the right knee; no medical man could have failed to appreciate the importance of these symptoms. Unfortunately from the surgeon's point of view two months at least were lost and the case rendered almost a desperate one. The man made a satisfactory recovery.

St. Thomas's Hospital House Appointments.

The following gentlemen have been selected as House Officers from December 5th:—

Casualty Officers (from January 1st, 1906): Senior, H. A. Kisch, M.R.C.S., L.R.C.P.; Junior, G. R. Footner, M.B., B.C.Cantab., M.R.C.S. Resident House Physicians: G. J. Langley, M.B., B.S.Lond.; C. L. Morgan, M.B., B.S.Lond., M.R.C.S.; W. O. Meek, M.R.C.S., L.R.C.P.; C. St. A. Coles, M.R.C.S.,L.R.C.P. House Physicians to Out-Patients: F. M. Bulley, M.R.C.S., L.R.C.P., M.A.Cantab.; R. C. Jewesbury, M.R.C.S., L.R.C.P., B.A.Oxon. Resident House Surgeons: L. E. C. Norbury, M.B., B.S.Lond., M.R.C.S.; D. K. Coutts, M.B., B.S.Lond., M.R.C.S.; J. H. Bletsoe, M.B., B.S.Lond., M.R.C.S.; R. J. C. Thompson, M.R.C.S., L.R.C.P. House Surgeons to Out-Patients: H. T. Gray, B.A.Cantab., M.R.C.S.; A. W. Hooker, M.B., B.S.Lond., M.R.C.S.; J. H. Drew, M.B., B.S.Lond., M.R.C.S.; H. Falk, B.A.Cantab., M.B., B.C., M.R.C.S. Obstetric House Physicians: Senior, J. M. Wyatt, M.B., B.S.Lond., M.R.C.S.; Junior, R. C. Whitting. M.A., M.B. B.C.Cantab. Ophthalmic House Surgeons: Senior, F. R. E. Wright, M.B.Lond., M.R.C.S.; Junior, C. R. B. Eyre, M.R.C.S., L.R.C.P. Throat: R. H. Cotton, M.R.C.S., L.R.C.P.; F. S. Hewett, M.R.C.S., L.R.C.P., B.A.Cantab. Skin: W. C. A. Ward, M.R.C.S., L.R.C.P.; A. B. Howitt, M.R.C.S., L.R.C.P., B.A.Cantab. Ear: H. S. Sington, M.R.C.S., L.R.C.P.; F. D. Atkins, M.R.C.S., L.R.C.P.

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" SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 13, 1905.

THE GENERAL MEDICAL COUNCIL.

The work of the General Medical Council in investigating charges of " infamous " conduct on the part of duly-qualified practitioners suggests some consideration of the issues involved in that sordid function. It is undoubtedly a right and proper thing that there should be an executive body to administer wholesome discipline to our great and important profession. Viewed from some aspects, however, the judicial business of the Council is little more than a pathetic farce. Last week their dread sentence of removal from the *Register* was pronounced on various offenders. For all that, the unfrocked practitioner is free to return to the active exercise of his profession in the full and blessed assurance that henceforth he will be able to advertise wholesale, as some men are literally doing at the present moment, upon the hoardings in the street and in the advertisement columns of the public journals. From the moment that the Council expunge his name from the *Register* as an unqualified practitioner he is outside the jurisdiction of our governing body. The lawyers act more wisely. When the Incorporated Law Society strike a solicitor's name oft the Rolls they take care he shall no longer practise his profession. Should any outsider encroach in the slightest degree upon the legal preserves he is at once prosecuted with the utmost rigour that the law allows. The General Medical Council, however, are content to do things after a different fashion. Their energies are spent in hounding an offender out of the field of legal qualification, sometimes on a miserable pretext, as in that notorious case where a gentleman was proceeded against for using an American degree by the Council, in spite of the fact that he possessed in addition an English diploma. As the result of that deplorable persecution the unfortunate victim died, and an indelible disgrace was thereby inflicted upon the General Medical Council. Such a miscarriage of justice could never have been brought about had the general body of the medical profession been adequately represented in the Council. Their non-representative nature, indeed, constitutes a fatal flaw in the very foundation of that body. So far from seeking to remedy that defect, however, the Council resist all proposals to increase the number of direct representatives, in spite of the fact that the creation of every new university adds to the class representatives already present in an overwhelming majority. Nor can we recall a single serious attempt of the Council to widen the representative principle in their constitution. Representation in government spells responsibility. It also connotes care for the interests of the community to be governed. The General Medical Council have neither popular representation nor have they apparently the slightest sympathy with the needs, wishes and aspirations of the main mass of the medical profession. Otherwise, how could they go on year after year prosecuting medical men for purely ethical offences? If some wretched, struggling practitioner be driven by want into the devious by-paths of canvassing and other advertisement, the whole machinery of the Council is at once brought to bear upon him. Why should not the Council endeavour to protect qualified men from the competition of quacks, which starves the regular practitioner? The Council plead that they are there simply to administer a law, and that they must take matters as they find them. That is all very well, but had the Council realised the falsity of their position they would long ere this have taken steps to turn bad law into good law, and to secure an amendment of the Medical Acts, so as to create a Council on a representative basis with powers to suppress irregular practice outside as well as inside the medical profession. The views of the General Medical Council have necessarily much weight with the Privy Council. Who can doubt that if the General Medical Council made up their minds to agitate for a fresh constitution, that, sooner or later, it would be conceded by the Privy Council and by Parliament. There seems little chance, however, that the representatives of qualifying bodies who now compose nine-tenths of the General Medical Council will ever seriously take up any matter of vital interest to general practitioners. They are there for the purpose of protecting the interests of particular corporations and of a particular class, and it is hardly likely they will consent to any self-annihilating policy. But in spite of the darkness of the outlook, medical men will do well to inform themselves exactly of the powers, actual and potential, of the General Medical Council, and to lose no opportunity of agitating for reforms that are not only desirable, but elementary in their character.

TYPHOID LESSONS.

A well-known physician used to ask his students to pay particular attention to his lectures on typhoid fever; "for," he would tell them, " this disease will be worth £100 a year to you when you go into practice." At the present day the number of men who make £100 in any single year from attendance on patients with typhoid fever must be very small, and we make bold to say there is not a general practitioner in the country who receives that sum on the average. This is not because his fees have gone down, but because typhoid fever has declined. The disease is no longer a commonplace of existence. To the credit of the profession there may be set the fact that by its success in the prevention of typhoid fever, it has succeeded in substantially penalising its own pocket. But in spite of its decline typhoid fever is still endemic in most of the large cities and towns, and its complete eradication still remains an object of desire. The problem is often spoken of as though it were one of the water-supply, and it is said that given a pure water supply typhoid fever would cease to exist. In practice, however, the matter is not so simple, and the actual factors at work and their several influences can only be worked out by the study of the disease in its endemic or epidemic manifestations. A cogent and suggestive comparative study of the Lincoln, Worthing, and Maidstone epidemics has just been made by Dr. Christopher Childs, and presented to the Society of Medical Officers of Health; some of the conclusions based on the author's researches deserve careful consideration. The principal factor at work in all three epidemics was undoubtedly water, and placing these outbreaks side by side brings out a remarkable similarity in their characteristics. The first of these is that the epidemic storm is heralded by the occurrence of a group of cases of diarrhœa and odd cases of typhoid scattered through the town, or in special districts supplied by the contaminated water. Then for a period of three weeks the notifications rise to a maximum with appalling suddenness and intensity; they abate for the next three weeks, and then tail off fairly rapidly till zero is reached again. Now owing to the long incubation period of typhoid and to its indecisive preliminary symptoms, it may be taken that three weeks is the average time between the actual infection of the patient and the notification reaching the medical officer's hands, so that in the case of a brewing epidemic, even if the early feature—the occurrence of scattered cases of diarrhœa and typhoid—be recognised, the harm is probably done by the time suspicion is aroused, as the bulk of those who will form the victims of the epidemic will have been already infected. Dr. Childs maintains, with a good show of reason, that a large proportion of the later cases are not caused by the water infection that poisoned the earlier ones, but that they are secondary to the latter and infected directly or indirectly by them. At Lincoln the first warning of the outbreak was given by the typhoid notifications which, during 1904, had been but six in number up to December 2nd, rising to eleven during that month, nine of them being received in the last week. Fourteen cases were reported in the first three weeks of January, and then the storm burst, no less than 547 cases being notified by February 11th. The preliminary rise, coupled with the knowledge possessed by the medical officer of health, as to the questionable character of the water, caused him to have a sample of the Corporation water analysed in January. He received a report on the 18th to the effect that there were traces of sewage-contamination, and promptly had handbills circulated warning people to boil their water and their milk. By this means it may be presumed he was able to forestall the infection of a number of others who would doubtless have fallen victims, but what is even more certain is that even such intelligent anticipation is bound to fail entirely to prevent an outbreak, for by the time suspicion is well aroused a larger proportion of the population will already be infected. The lesson is obvious. *Si vis pacem para bellum.* It is no use trying to prevent an epidemic of typhoid by panic-stricken measures at the last moment; immunity can only be obtained by organised effort in time of peace. Nothing could be clearer than that the Lincoln epidemic, like that of Maidstone and of Worthing, was due to contamination of the water. The bulk of the City was supplied by the Corporation works which drew their water from the river Witham and its tributaries the Pik and the Catchwater. These are all sluggish streams winding through flat alluvial country, freely open to contamination from man and beast along their whole course, whilst the Witham itself actually receives the effluent from the Grantham sewage-farm and 1,200 yards above the Lincoln intake—that of the County Asylum Sewage farm. The Maidstone epidemic was plainly caused by the fouling of the springs drawn upon for the supply to the Farleigh district, and that at Worthing, which derived its water from deep wells in the chalk, by the contamination of these wells by the outflow from some badly-made drains and sewers which filtered through fissures in the chalk. Now unfortunately analysis, bacteriological and chemical, does not necessarily give authentic information as to fouling by sewage, for in the middle of the Worthing outbreak chemical analysis failed to reveal that the water was contaminated. Dr. Childs rightly and properly insists not only on the importance of deriving water from irreproachable sources, but on the necessity of giving the medical officer of health power to supervise those sources and to keep a constant patrol at work to detect and prevent any possibility of their being fouled. Until scientific knowledge of water analysis is far more advanced than it is, such supervision is a most important, nay, an indispensable, concomitant of preventive medicine. We cannot regard these three epidemics without misgiving: Worthing, Maidstone, and Lincoln up to the time of their occurrence had enjoyed exceptionally good health, but they were living on the edge of a precipice, and a slight accident was all that was needed to cause disaster. When we consider the position of hundreds of towns and villages at present, even the position of London itself, we are inclined to ask, How many are living in a fool's paradise.

Notes on Current Topics.

Sleep, Normal and Abnormal.

It is an old reflection that many things which as phenomena are among the most familiar, are in their essence and causal relations far from being understood. What is first in the *ratio essendi*, to use the Baconian phrase, is often last in the *ratio cognoscendi*. It is so with sleep. From our earliest times sleep is with us, rounding off our days, of all things the most familiar, but the wisest of us are as babes in attempting to explain it. It is true that there are certain theories, more or less trustworthy, as to the physical and physiological accompaniments of the condition, but they, after all, do no more than border the fringe of the subject. As to the real cause of sleep, the condition which governs it, and the fine distinctions between it and the waking state we know nothing. Most of us suffer great inconvenience and feel imperative demands for sleep if we go without our seven or eight hours in the twenty-four. Nevertheless, there are many people who keep in perfect health with four, five, or six hours' sleep in the day, and they are generally people of bright intellect and keen energy. It is said, for instance, that the elder Pitt rarely slept more than four or five hours at a time, and Napoleon was satisfied with an equally short repose ; indeed, in times of great strain, as in the fatigue and anxiety of the Egyptian campaign his biographers relate that Napoleon rose quite fresh from daily periods of not more than one or two hours' rest. During the greater part of John Hunter's active life, his sleep rarely occupied more than five hours in the day. Jeremy Taylor, also a man of great active intellect, found his needs satisfied by three hours' sleep. On the other hand, there are many individuals who require much more than the average eight hours' rest. In women more than in men, and in those of phlegmatic disposition rather than in those of alert mind, longer periods of slumber are required. Passing to distinctively pathological cases, there have been recorded on more or less trustworthy grounds many instances of prolonged sleep, varying in length from a few days or weeks to several years. In 1880, Hargreaves reported a case of a female patient who was said to have slept continuously for nine years. Slaughter, in 1867, reported the case of a young woman said to have slept for eighteen years, micturition, defæcation and menstruation taking place regularly. Equally curious are the alleged instances of suspended animation, or very deep sleep, brought on voluntarily by Indian fakirs. Experiments have been made by Dr. Patrick and others in America which seem to show that all attempts at forced deprivation of sleep fail after a certain time—probably rarely more than three weeks. It used to be a mode of punishment in China to condemn a criminal to death by depriving him of sleep, and it is said that after seven or eight days of enforced wakefulness the victim usually became maniacal. We suppose that some time we may hope to learn something of the nature of sleep, its physiology, psychology, and pathology, but all that has been done up to the present is to collect a more or less useful mass of isolated facts.

Football.

There is always a good deal of talk every winter as to the danger of football, especially Rugby football, and there are plenty of people who decry the game as a relic of barbarism, inconsistent with latter-day civilisation. Certainly in America an amount of license is allowed to players that would quickly be suppressed by an English referee. Accidents of a serious and even fatal nature are not uncommon, and in big matches surgeons and stretchers are part of the field equipment. President Roosevelt, who cannot be accused of erring on the side of namby-pambiness is credited with the intention to reform the game, his own son having lately had his nose smashed and been badly mauled otherwise in a Harvard match. The American game has advanced even on the Rubgy rules and in hard-fought games players protect themselves with all sorts of guards and pads before entering the lists. In England the Rugby game, which has lately lost something of its *quondam* popularity, is likely to receive a fresh impetus from the visit of the New Zealanders, and it is much to be hoped in the interests of a fine manly sport and of general humanity that the Rugby Union will sternly discountenance any attempt to introduce rougher and more "strenuous" methods. The great advantage that "Rugger" possesses over "Soccer" is that it is free from professionalism, and that the game is played for sheer love of sport and from exuberance of spirits. That it is possible to play hard and to play well is shown by the immunity from serious accident that has attended the team of "All-Blacks," who have gone through twenty-five contests in the last few weeks—without any players being seriously disabled. The safety of the game depends on the referees, and in their hands lies its future. As Rugby is played now, it is not nearly so dangerous to life and limb as hunting or steeple-chasing, and fortunately a doctor is not a *sine quâ non* in its Homeric contests.

Nature of Trachoma.

The ultimate pathology of trachoma still remains a matter of considerable doubt. Although the conjunctival secretion in cases of granular lids has frequently been found to contain micro-organisms, notably the gonococcus, no constant bacterium has been discovered which fulfils the requirements demanded of a causative organism. The disease, however, is one of great importance, and a new and suggestive light on it is thrown by a paper by Goldzieher in the *Berlin Klinische Wochenschrift* for October 9th. The writer says that the disease was imported into Europe, in which it was not indigenous, by the French army—after Napoleon's Egyptian campaign in 1798 After the victory of the Pyramids the French troops were attacked in large numbers by an eye-complaint which up till then was unknown and which was really trachoma. Originally the disease was an acute blenorrhœa, and Goldzieher holds that it was a true gonorrhœal conjunctivitis, which in process of time has changed its character till it has reached the milder but far more chronic form in which the complaint is now met with. Some authors deny this conclusion on the ground that gonorrhœal conjunctivitis never becomes chronic, but Goldzieher asserts that when one eye is affected by acute gonococcal conjunctivitis, granules, such as occur in trachoma, not infrequently are found in the conjunctiva of the other eye. Moreover, he maintains that acute conjunctivitis of one kind and another does at times actually lead to chronic ophthalmia which is indistinguishable from true trachoma, and that therefore such a sequence from gonorrhœal ophthalmia is not lightly to be put aside. The theory is an interesting one, but certainly cannot be regarded as proven.

Transplantation of Organs.

WITH the knowledge of improved technique in aseptic surgery, considerable advances have, of course, been made in experimental physiology, and in no branch of the subject is this more true than in that relating to the transplantation of organs. It is now possible, by a rigorous adhesion to aseptic principles, successfully to perform operations on animals which a few years ago would have been quite impracticable. Thus, Carrel and Guthrie, of Chicago, have succeeded in transplanting the kidney of a dog to the cervical region, and by establishing a circulation, restoring its function. Examined a few days after operation, the transplanted kidney was distinctly larger than it had been, and its circulation was increased. The secretion, also, was greater than that of the other kidney, and contained somewhat a larger percentage of chlorides. It has been pointed out by many observers that organs grafted between animals widely different in species always fail, while grafts between animals of the same species though of different varieties always succeed. It is suggested that by making use of the thyroid glands of anthropoid apes it may be possible to supply a permanent cure for diseases such as myxœdema due to disappearance of the thyroid function. It is possible, too, that in time it may be found practicable to treat diabetes by transplantation of a pancreas or part of a pancreas.

Nutmeg—An Ecbolic.

AN unusual case of poisoning from taking the whole of a grated nutmeg in a half-quartern of gin was reported by Dr. James Hamilton in our last issue. The object with which the patient had taken this quaint mixture seems to have been to bring on an overdue menstrual period, and our correspondent states that he had not heard before of nutmeg being used as an abortifacient. We believe that in England among a certain class half a nutmeg in gin or hot wine is held in high repute for this purpose, and it is said to be very effectual. In France nutmeg is highly regarded for the same property. Not only are it ecbolic properties held in veneration by the people, but the authorities acting on the same supposition do not allow nutmegs to be sold except at a chemist's. Drysalters, moreover, are not allowed to use them in their work. There is little or no evidence in English medical literature as to whether or not nutmeg really acts as an ecbolic, and we should be interested to hear if any of our readers have come across any evidence on the point. The essential oil is prized for its stomachic and carminative properties, and is frequently prescribed by some practitioners for dyspepsia and flatulence. It can hardly be this constituent of the nut, however, which possesses ecbolic properties, or the fact would have been recognised long before, and, indeed, oleum myristicæ seems to have much the same pharmacological action as the other oils of its class. If any constituent be really abortifacient it would most likely be myristicin, but it is doubtful how far it could be of use for the purpose. All ecbolics are notoriously unsatisfactory, and if nutmegs belong to this class at all, it is difficult to believe that it is a very active member of it.

Death from Drowning.

THERE has been a good deal of discussion in the past as to the exact length of the different stages of the process of death from drowning, and a good deal of difference of opinion on the point. It is obvious that the opportunity of direct observation cannot be got in the case of human beings, and conclusions drawn from experiments on animals must be regarded as untrustworthy. It is extremely improbable that the period of drowning is the same in man as in any of the animals commonly used for experimental purposes, and we are quite at a loss in attempting to establish any ratio between them, depending on body-weight or other such data. The periods accepted by Brouardel may perhaps be regarded as the best founded, though some authorities think he makes them too short. According to him the stage of suspended respiration lasts something over half a minute, the stage of dyspnœa about twice as long, and the final stage of exhaustion for a minute and a half. During the stage of dyspnœa, the subject makes deep inspiratory movements, drawing much water into his lungs. Of course, in an ordinary drowning accident, the total period occupied is much longer, as the victim may rise to the surface once or twice and obtain some air. In the case of fatigued swimmers, on the other hand, the period is shortened, as fatigue may diminish the ordinary periods by quite a half. The practical lesson to be drawn, therefore, is that at sea-bathing resorts attendants should be so stationed in boats that they may reach the drowning person in one minute at the outside.

Cancer Curing.

In a recent number of the Medical Press and Circular we took occasion to congratulate Dr. Fenwick, of Accrington, on his successful prosecution of the editor of a local paper for libel. The journal in question had made certain statements reflecting on the plaintiff, which it was unable to maintain in court, and Dr. Fenwick was awarded £1,000 damages. In the pursuit of a difficult calling like that of medical practice it is impossible that mistakes should not occur, and we are always glad to see a colleague able to clear his character from unjust aspersions. It is with considerably less satisfaction that we read in a leading London daily that Dr. Fenwick has communicated to its Accrington correspondent a claim that he is able to cure cancer by a " secret remedy." It is said that Dr. Fenwick would have preferred that no details should yet be published, but as the paper continues to give statements in Dr. Fenwick's name, we should be glad to hear that they have as little authority for using his name as had the paper which he recently prosecuted. Eight or nine cases of cancer are said to have been already cured, details of two of them being given. Neither of them as reported carries conviction, and, as we have said over and over again, results of such importance as the genuine cure of cancer ought to be submitted for the criticism of the profession, through its recognised organs, before reliance can be placed on them. The article that describes this treatment contains the usual embellishments of the lay reporter and the profound refections on pathology for which that individual is so justly famed. It is to be hoped that the " inspiration " of the article will be categorically denied.

Health Among the Esquimaux.

Not the least interesting of Professor Senn's experiences in his recent tour round the world is that among the Esquimaux, and in a recent number of the *Journal of the American Medical Association* he relates his impressions on medical affairs among that interesting people. His remarks regarding the healing of wounds and the conditions of infection are instructive. As a rule wounds heal rapidly, and without suppuration, the dressing in universal use being the bare side of an animal's skin. Is is probable that suppuration never occurs unless the infecting organism be imported from other regions, and that the air of Greenland is practically free from pyogenic bacteria. On the other hand, Esquimaux on board ship are peculiarly liable to suppurative conditions of all kinds. It is probable therefore that, owing totheir lack of exposure to pyogenic organisms, Esquimaux have hardly developed any resisting power. Dr. Senn is convinced that no tumours of any kind are to be found among the inhabitants of the Arctic region, and he hazards the guess that this may be due to their highly iodised diet. The parturient woman is carefully segregated during labour, but immediately the child is born, the mother resumes her place in her household. In spite of the very small attention given to them, Esquimaux children seem uniformly healthy.

Japanese Medical Education.

The Land of the Rising Sun is supposed at the present moment to represent the sum of crystallised occidental wisdom, *plus* a vigour of national life that leaves the old western world toiling painfully in the rear. There is a certain amount of truth in a conception of this kind, but it is far from containing the whole truth. For instance, a five years' course of medical study is not yet demanded of its budding practitioners. The regulations for the curriculum which have lately been laid down for the Tokyo Charity Hospital Medical School are before us, and we notice that only four years' study are required of the students. The course is comprehensive, the only notable omission being biology. With his application for admission to the school the student must furnish a certificate of having passed the middle school examination ; and certificates of character, constitution, and mental ability ; and a biography of himself. A stringent attendance is evidently to be insisted on, for no student who has not attended two-thirds of the lectures will be allowed to sit for the examination at the end of the term, and without passing that examination he cannot proceed to the next step in the curriculum. Two qualifying examinations have to be passed. The first, at the end of two years, includes second M.B. subjects with chemistry and physics ; the second at the end of the fourth, medicine, surgery, ophthalmology, midwifery, gynæcology, pathology, practical pathology, and hygiene. Practical work is rightly insisted on in all examinations. It is especially interesting to note that though not a qualifying subject, the student has to attend classes on the English language during every term of study. Though this may seem flattering to ourselves, we fancy it is even more of a compliment to America, for that country seems to have a large share in influencing Japanese medical thought.

Buccal Auscultation.

It is now some thirty years since Galvagni drew attention to the value of buccal auscultation in the examination of diseased conditions of the lungs, but the method has hardly up to the present received the attention it deserves. Indeed, there are but few physicians who systematically practise it, although it gives valuable help in the early diagnosis of some diseases. The patient should be placed on his back, resting on a high pillow, and he should be induced to cough several times so as to clear his trachea and bronchi as free of all obstruction as possible. He should then be instructed to hold the mouth half open, and to breathe quietly and deeply. The chest sounds can be heard by approaching the ear to the patient's mouth. In cases of phthisis where softening is taking place, the so-called "buccal rale" is heard. It closely resembles the fine rales heard at the apex in similar cases, but may be present where the latter are absent. In very few cases other than phthisis is the rale heard, and where it does occur it is found that there is some lesion of the apex of the lung.

The Hygienic Treatment of Rheumatism.

Most practitioners of experience are agreed that chronic muscular rheumatism is a disease peculiarly refractory to drug treatment. Anti-rheumatic nostrums of all sorts have been employed, and most medical men are gradually returning to old-fashioned remedies and treatment by tonics. It is surprising, however, in many cases to find what considerable relief can be given by general hygienic care. The rheumatic subject is generally a person of "bilious temperament"; he has a dull, heavy eye, a furred tongue, an offensive breath, lack of appetite, constipation, and headache. Although he never has a healthy appetite, he frequently eats and drinks if not in excess, at any rate in full amount. The first indication in such a case is to relieve the toxæmic condition of the body by a free purge. This having been done, one is free to make a new start, discarding entirely the use of drugs. It may be necessary, if the patient's teeth are defective, to order repairs, and in any case it will be advisable to give explicit directions as to the nature of the food and the method of masticating it. Muscular exercises should then be ordered, the muscles most affected being most exercised. If the arms and shoulders suffer, then Indian clubs may be employed; if the legs, proper gymnastic movements. In addition thorough massage of the abdomen should be practised by the patient himself. In most cases it will be found that a few weeks of such treatment will put a patient in better physical condition than he has enjoyed for years.

The Election of Direct Representative for Ireland.

As the time approaches for the election of a direct representative for Ireland on the General Medical Council, interest in the event intensifies. Sir William Thomson's term of office terminates on February 28th next. The usual advertisements giving notice of the election will be issued in January, and the President of the Council, as returning officer, has named January 18th as the last day for the receipt of nomination papers. The result of the election will be made known on February 8th. Up to the present two candidates are before the medical profession, Sir William Thomson, the existing member, and Dr. Leonard Kidd, of Enniskillen, who opposes him. Each candidate may be regarded as a good representative, the one of the consultant, the other of the general practitioner class in Ireland, and therefore it is unlikely that at the eleventh hour a third name will be brought forward. We referred last week to Sir William Thomson's action in bringing before the General Medical Council the condition of the Irish Poor-law Service. This action has called forth in the daily press a letter from Dr. Kidd, who considers that it will be received with approval by those in favour of the election of a general practitioner as representative. Dr. Kidd continues:—"Whether the Council have power to act on his suggestion or not remains to be proved; but the fact of the Irish Poor-law Medical Service being brought under the official notice of the Council by the direct representative of Ireland at this the eleventh hour of his second period of five years (after ten years' silence), when a fresh election is impending, is an instructive demonstration of the value of opposition and competition." This letter has drawn a reply from Sir William Thomson, in which he refers to Dr. Kidd's evident wish to displace him and consequent desire "to score a point to my detriment." He then denies Dr. Kidd's statement that for ten years he had done nothing for the Poor-law Service, and states that several years ago he wished to bring the subject before the Council, and consulted the then President, who decided that the matter was entirely outside the scope of the Council's powers. Sir William Thomson adds that the reason the discussion on the Service came on at the last meeting was a decision of the Council on another subject, which, to his mind gave the opportunity he desired, and the President permitted the discussion. "The implication that I selected the time because it was near an election is quite unworthy and absolutely baseless."

Disorderly Proceedings at the Royal University of Ireland.

There was issued during the past week to the members of the Senate of the University a "Statement of Proceedings in Reference to the Disorder which occurred at the Conferring of Degrees on October 27th, 1905." The "Statement" refers to the speech made by Lord Meath on the occasion; to the meeting on Nov. 7th, when the Vice-Chancellor presided in the absence of Lord Meath, and at which Mr. Doyle, the Assessor to the Senate, gave his opinion, which was in substance that the Senate had no power to punish the students who took part in the disturbance. Mr. Doyle was of opinion, on the whole, that a conviction in a court of law would be the more appropriate method of proceeding. This opinion is based on Sections 4 and 11 of the Charter of the University, which state the powers given to the Senate, and which do not include disciplinary powers. The Senate, it appears, has power in common with all such bodies, of framing rules which, when approved by the Crown, would enable them to exercise disciplinary powers in cases such as the present. The opinion of the Law Officers of the Crown, on the other hand, is to the effect that every corporation created by statute or by charter, or by both, and, in the absence of any provision to the contrary in the Act or instrument created as incidental to its existence, and is necessary for the performance of its functions, has power to *amove* its officers or members for just cause. A university is not an exception to this rule, and there are not in any Act or in the Charter any provisions to deprive the Royal University of this inherent power. The matter now awaits the decision of the Senate as to its next step.

Death of a Lunatic at Hove.

A coroner's jury at Hove last week returned a verdict of manslaughter against the widow of a medical man, under whose care a lunatic lady had died. The *post-mortem* examination revealed the facts that the body was sore and emaciated, the hair matted and three ribs broken. The jury found that death was accelerated by neglect and the want of food and medical attendance. Deceased was fifty-one years of age and had been certified since 1885. It was shown in evidence that the original sum paid for maintenance was £80 a year, which was eventually reduced to £60 a year. A guinea a quarter was paid for medical attendance. If these facts be corroborated, it seems an extraordinary thing that such a state of matters could have been for a moment sanctioned by the Lunacy Commissioners. Can the emaciated and neglected state of the patient have escaped notice at their periodical visits? Surely it is the duty of the Commissioners to ascertain that adequate payment is made for patients, and if that be not forthcoming to see that asylum treatment be provided. What reasonable person could expect a sick lunatic to be adequately fed and nursed for £60 a year? Then, again, was the quarterly guinea fee payable for an inspection visit, or was it to cover medical attendance? Anyway, it seems from the evidence that the guinea was not invariably handed over to a medical man. The whole incident suggests a deplorable laxity on the part of the Lunacy Commissioners, although it may be, of course, that there are explanatory circumstances that have not become public. Will the matter end here?

Fatal Cigarettes.

Modern man is a curious animal. In his tastes and habits he often flies straight in the face of Providence. One of his most deeply-rooted weaknesses is the smoking of tobacco, which he insists upon having at all costs, whether the payment be exacted from mind, body, or estate. Witness the millions drawn by the Chancellor of the Exchequer every year by the tax upon tobacco. Willingly does the consumer contribute the crafty burden of indirect taxation by paying fourpence or sixpence for a pennyworth of the prized leaf. Formerly he was addicted to the uncleanly habit of taking tobacco in the form of snuff. Then he gradually settled down to pipes and cigars, with some small margin of chewing. During the past generation, however, the population of the United Kingdom have swayed the wave of fashion towards cigarette-smoking, that is to say, to that form of consumption of tobacco which is the most deadly and injurious as yet devised by the perverted art of man. The cigarette is to the smoker as brandy to the toper. In excess, it ruins his stomach, his heart, his temper, and eventually his brain. The worst feature of the case is cigarette smoking amongst boys. What is bad for men is often fatal for boys. Only last week a Yorkshire jury found that the death of a lad was due to excessive cigarette-smoking. Although only sixteen years of age, he was described at the inquest as "a heavy cigarette smoker." If physical deterioration be among our generation some part of the blame may assuredly be laid at the door of the foolish habit of smoking cigarettes in season and out of season.

A Tax Upon Plum Puddings.

The bare mention of a tax upon plum puddings is calculated to send a thrill of horror throughout Christendom. For years past the atmosphere of British politics has been thick with themes of taxation, and every one of every shade of politics has by now made up his mind upon such points as raw material, dumping, fiscal tariffs, retaliation, protection and what not. All that kind of thing is very well in newspapers. It is even desirable that some knowledge of political economy should be a part of every man's education. But when plum pudding is introduced into the controversy, it is time to leave the armchair and sally out into the market-place. There could be no greater rallying cry for Britons than the defence of plum pudding. Now, the taxation of the multitudinous ingredients of plum pudding amounts to a tax on the finished article. If a tax be put upon corn, it is put upon flour and upon bread, which form the main buttresses and substance, so to speak, of that ever-hallowed dish. But do the men of Britain realise that they are already paying a dastard tax upon their plum-pudding? Amongst other foodstuffs taxed by Government is an incredibly mean one upon dried fruits. What would a plum-pudding be without its currants, raisins, and its candied peel? Of all these the raisins of Spain form its chiefest treasure-trove of embroidering sweetness. Your cunning housewife insists upon having the raisins of sunny Valentia and will have none of your counterfeits drawn from less-favoured climes. Let politicians introduce, for once, a real cry into their party strife: "A free plum-pudding!" When that is obtained there can surely be little thenceforth to fight about in Parliament.

The Logic of Thought-Healing.

It is abundantly evident from a consideration of the enormous sums expended upon quacks and quack remedies that the reasoning power of the average Briton must be at an exceedingly low ebb. A moment's thought should convince even a shallow brain that the worst qualified medical man must be infinitely better than the best unqualified and untrained pretender—*alias* quack. But nothing seems to deter the man or woman bent upon a course of quackery. A university education, indeed, seems to lay its possessors eminently open to the snares of the charlatan. Clergymen of every cloth are enmeshed in great shoals. Even the repeated publication of the formulæ of quack remedies and of their value does not prevent the sale of nostrums at many hundred times over their cost price. What does it all mean? The only answer possible is that the average citizen is not trained to reason, or if he be able to think and argue soundly on some points, yet his mental sanity forsakes him when confronted with the brazen assurance of the patent medicine monger and the quack. In other words, the huge fortunes amassed by these harpies of society depend upon a sort of monomania. A first-rate example of the kind of stuff that passes for reasoning amongst the thought healers may be taken from a recently reported lecture of Miss Anna W. Mills, of the U.S.A.:—"A dead body can't take cold," she explained to her audience. "The only difference between a living person and a dead body is the fact of the living being possessing mind, and the dead body doesn't. Then why, if mind can't catch cold, should the living body be subject to colds and the dead body free from them?" The authoress of this intellectual masterpiece was unable later to give a clear answer as to the value of thought-power in toothache, and appears to have evaded the question as to whether it would not be better to pluck out an offending molar than to trust to the mesmerising of a rebellious "ego."

Re-organisation of the Irish Medical Association.

Since our last issue information has reached us that the proceedings of the Irish Medical Association at the two recent special general meetings have been declared by counsel to be, at any rate in part, invalid. It appears that at the first special meeting, held on October 31st, certain of the articles on which there was a difference of opinion were carried by less than the three-fourths majority required by company law. The point was raised at the second general meeting by certain members of the Association who had fortified themselves by counsel's opinion privately obtained. The Association, while proceeding to deal with the articles as if legally before them, directed their solicitor to state a case for counsel in order that they might be sure of their position before laying the articles before the Board of Trade. Opinion has now been given that certain of the articles, notably that dealing with the constitution of the new Council, have not been solidly passed. Although this muddling hardly reflects much credit on those responsible for the management of the special meeting, it is not altogether a matter of regret, since it gives an opportunity for reconsidering the principles embodied in the invalid articles. The scheme, which now, by counsel's opinion, is still in the air, could hardly have had other result than the metamorphosis of the Irish Medical Association into a Poor-law Officers' Association, instead of making it, in fact, as well as in name, the Association of the Irish medical world. Our Irish readers will find further remarks on the subject in this week's Supplement, and we hope to devote more space to it at an early date.

The General Medical Council and Advertising.

Readers will find in the advertisement columns of our present issue an important notice from the General Medical Council. It calls the attention of general medical practitioners to the questions of advertising and canvassing for patients. Action of that kind is constantly before the Council, a great deal of whose time is devoted to adjudicating upon such offences. It is to be hoped that a more general appreciation of the attitude of the Council towards the employment of agents or canvassers, or of the issue of advertisements, will act as a salutary warning to those who may be led, through carelessness or unwisdom, to sanction such undesirable methods of acquiring practice. The penalty of being struck off the Register is one of terrible severity, and as it may be presumed the desire of the Council is to exercise a deterrent rather than a retributory action, it follows that the more publicity given to their policy the better for everyone concerned. Of all men, the advertising practitioner is pre-eminently penny-wise and pound-foolish.

PERSONAL.

H.R.H. Princess Henry of Battenberg opened on Friday the new Hammersmith Workhouse and Infirmary which have been erected in Ducane Road, Wormwood Scrubbs. The cost of the building, apart from the site is £207,000.

Mr. Macleod Yearsley, F.R.C.S., has been appointed the Official Delegate of the Otological Society of Great Britain, at the forthcoming International Medical Congress at Lisbon.

Field-Marshal Earl Roberts, V.C., has consented to preside at a festival dinner on April 3rd next, at the Whitehall Rooms, London, in aid of the funds of the Royal Nationatl Hospital for Consumption, Ventnor.

In the distribution of the large charitable bequests left by the late Mr. Henry Bloom Noble, the trustees have notified their intention to found a new hospital in Douglas at a cost of £20,000, with a free site and £20,000 towards its maintenance, and a cottage home for 100 children.

Mr. Roosevelt has appointed a commission of three surgeons-general, representing the army, navy, and marine hospital service, to inquire into the conditions prevailing in Government offices and workshops, and to recommend measures for the prevention of tuberculosis therein.

The health of Abdul Hamid is again a source of anxiety to his attendants. The malady from which he is suffering is now said to be consumption.

Sir Otto Jaffe, ex-Lord Mayor of Belfast, has given, writes our correspondent, the munificent sum of £3,000 in addition to the £1,000 previously promised to the Queen's College Equipment Fund, thus securing the sum of £20,000 generously offered by Sir Donald Currie on the condition of a like sum being contributed by others.

The wills of two deceased members of the profession were proved last week; that of Dr. W. Hooper Masters, late of Barnes, in the sum of £22,628, and that of Dr. Farquhar Matheson, Surgeon to the Royal Ear Hospital, London, in the sum of £17,656.

Prof. E. F. Trevelyan of the University of Leeds has consented to give the Introductory Lecture to the Spring Post-Graduate Course in connection with the Mount Vernon Hospital for Consumption, and Diseases of the Chest, the subject being "Sanatorium and Institution Treatment of Pulmonary Phthisis in Relation to Large Centres of Population."

Dr. Theo. B. Hyslop, Medical Superintendent of the Royal Bethlem Hospital, will open a discussion on "The Vitality of a Nation," at the next meeting of the Society for the Study of Inebriety on January 9th, 1906, at 4 p.m. in the Rooms of the Medical Society of London.

Last week Mr. J. H. Ray, F.R.C.S., was elected to the office of honorary assistant surgeon to the Manchester Royal Infirmary.

The Council of University College, London, has conferred on Dr. Geo. A. Buckmaster the title of Assistant Professor of Physiology.

Mr. P. M. Heath, F.R.C.S., has been reappointed by the council of University College Surgical Registrar to University College Hospital, London, for a further period of one year from January 1st, 1906.

We understand that Baron Tagani, formerly Surgeon-General to the Japanese Army, is leaving on December 26th for America, where he will lecture on military sanitation. He will afterwards proceed to England, where he will endeavour to arrange for the affiliation of the Japanese medical colleges with the British medical colleges.

The five-yearly Humbert prize established for the encouragement of orthopædic science has been awarded to Professor Charles Vulpins, of Heidelberg University,

Mr. E. E. Cumberbatch has been elected president of the Otological Society of the United Kingdom.

Special Correspondence.

[FROM OUR SPECIAL CORRESPONDENTS.]

SCOTLAND.

The Professorship of Anatomy in Melbourne University.—On December 4, the Chair of Anatomy in the University of Melbourne was filled by the election of Dr. R. J. A. Berry, who has for the past nine years been a deservedly successful and popular lecturer on anatomy in the New School, Edinburgh. While Professor Berry's numerous friends in Edinburgh and out of it will hear of his departure for the antipodes with regret, they will heartily congratulate him on his appointment to so important a chair, and not less heartily congratulate the University of Melbourne on securing one who, judging by his past record, will unsparingly devote himself, both to the advancement of the scientific study of his subject, and to the furtherance of efficiency in all matters of medical education.

The Old Infirmary, Edinburgh.—Few buildings in Edinburgh are of more historic interest than this, which is now, after a chequered career, being converted into the engineering department and physical laboratories of the University. In 1578 the first high school was built on this site, on land formerly the property of the Black Friars—to whose church John Knox was summoned in 1556 to answer for his denunciations of the mass. The old school was bounded by the Flodden Wall in 1513, parts of which can still be seen, and was rebuilt as the present edifice in 1779. From this date to 1829, the children of the burgesses were taught within its walls, and when the present High School on the slopes of the Calton Hill was opened, the building was sold to the Managers of the Royal Infirmary to be utilized as the surgical house, the original old Infirmary buildings being restricted to medical cases. When the present infirmary was opened the medical house was demolished, and the surgical house converted into an hospital for infectious diseases, first under the Infirmary managers, then under the town. Finally, on the opening of the Colinton Mains fever hospital the building was acquired by the University. School, hospital, university, the building has played no unimportant part in Scots' educational affairs. May its future be as successful as its past.

BELFAST.

Queen's College Better Equipment Fund.—To the great satisfaction of all old students and friends of Queen's College the sum of £20,000 which was needed to take advantage of Sir Donald Currie's generous offer of a like sum, has been raised. The amount stood at about £17,000 last week, and only the few remaining weeks till December 31st were left to raise the necessary total, when Sir Otto Jaffe, the ex-Lord Mayor of Belfast, and Chairman of the Fund, came to the rescue with a donation of £3,000, in addition to £1,000 given previously. This places it beyond all doubt that the College will have a sum of at least £40,000 for its better equipment, and possibly considerably more, for "nothing succeeds like success," and smaller sums are daily coming in. The money will not be spent in buildings, but in providing additional lecturers and demonstratorships in various departments, both Arts and Medical. Such appointments are really essential to a progressive school, for not only do they increase the efficiency of the teaching, but they serve to attract good men to the school, and keep them at it for a year or two after graduation. At a special meeting of old students and friends of the College on Friday last, special resolutions of thanks were passed to Sir Donald Currie, Sir Otto Jaffe, and all who had helped to bring about the successful issue, and also to President Hamilton, to whose energy and devotion the scheme owes its inception and not a little of its success.

Maternity Nurses and "Handy Women."—When opening a sale of work for the Belfast Maternity Hospital last week, the Dowager Marchioness of Dufferin and Ava made some excellent remarks on the subject of maternity nurses, and spoke in strong language of the responsibility incurred by Poor-law guardians who now have the power of appointing properly trained maternity nurses wherever they are required. The days of Gamps and handy women were, or ought to be, over, and she thought it a disgrace now for any town or district which could have certificated and registered midwives to allow women and children to run the risks they do at the hands of ignorant persons.

An epidemic of measles has broken out in Dundee, and as a result the attendance of children at the schools has been affected to a considerable extent.

Correspondence.

COUNTRY DOCTORS AND COUNTRY PARSONS.

To the Editor of The Medical Press and Circular.

Sir,—Such is the heading of a short editorial in your last issue, but how very full of significance! What a serious undertaking for the parson to attend to both the religious requirements of his flock, and to minimise the physical strain of the doctor. Medicine and theology often wander hand in hand, but I fear it is a case not of the linking of hands of different individuals but of the right hand holding the left of the same individual. The right hand doles out religious and the left medical comforts. Granted that a parson carries round his parish a clinical thermometer, I doubt whether his interpretation of the significance of the recorded temperature would be acceptable to, or accepted by, his medical colleague. We know too well that a little knowledge is a dangerous thing. In my experience I have found that the knowledge of parsons in matters medical is almost confined to the knowledge of " patent medicines, " teething powders," and so-called " lung tonics." I have noticed, too, that parsons have a marvellous power of lightning diagnosis. Of course, there are exceptions to the rule, and I know several of these parsons, men who increase the confidence of the patient in their doctor, who constantly impress upon patients the futility of seeking the advice of a doctor if such advice be not consistently followed, and who advise the sick parishioner never to initiate a step in dieting or treatment without first asking the medical adviser. No! Mr. Editor. We must " clip " the wings of the parson and not incubate them. If we do, the parson will fly away with even the remnant he so far has allowed us to retain. We must never allow the parson to assume control over us. Let each of us stick to our own last.

I am, Sir, yours truly,
December 6th, 1905. S. J. R.

DR. GOOCH AND LORD NELSON AT YARMOUTH, 1802.

To the Editor of the Medical Press and Circular.

Sir,—At the present time any reminiscences of Nelson have a peculiar interest. I therefore record some facts relating to Dr. Gooch, the well-known Professor of Midwifery at St. Bartholomew's Hospital, in the early part of the last century, who was a young pupil of Mr. Borrett, surgeon, of Yarmouth at the time of the battle of Copenhagen.

The following is an extract from one of young Gooch's letters, which may now be of interest :—

" I was," he says, " at the Naval Hospital at Yarmouth on the morning when Nelson after the battle of Copenhagen, having sent the wounded on before him, arrived and landed at the Jetty.

" The populace surrounded him, and the military were drawn up in the Market Place ready to receive him; but, making his way through the dust and the crowd and the clamour, Nelson went straight to the Hospital.

" I," continues Gooch, " went round the wards with him, and was much interested in his demeanour, to the sailors; he stopped at every bed, and to every man he had something kind and cheering to say.

" He stopped at one bed in which a sailor was lying who had just lost his right arm at the shoulder, and the following short dialogue took place :—

" Nelson : 'Well, Jack, what is it with you ?'

" Sailor : 'Lost my right arm, your honour.'

" Nelson looked down at his own empty sleeve, then at the sailor, and said playfully : 'Well, Jack, you and I are spoiled for fishermen.'"

" Nelson passed on to the next bed, but his cheery words had a fine effect, for I saw the poor fellow's eyes sparkle with delight as Nelson turned away to pursue his course round the wards."

I am, Sir, yours truly,
John C. Thorowgood, M.D.
Bognor, Sussex, November.

Obituary.

DR. JAMES LYNASS OF BELFAST.

A painful sensation was caused in medical circles by the news of the sudden death last week, of Dr. James Lynass, of Belfast. Dr. Lynass had gone to bed in his usual health, apparently. During the night he woke Mrs. Lynass and complained of headache; he shortly became unconscious, and died before morning, evidently from a cerebral hæmorrhage. About a year ago he had a long and severe illness arising from septic infection, and at intervals since then he had slight attacks of indisposition, which, though not severe in themselves, seemed to show that the former illness had never been quite recovered from. It is thought probable that a septic embolism had weakened the walls of a cerebral vessel and so led to this fatal hæmorrhage, so unusual in a young man. Dr. Lynass studied in Queen's College, and graduated in 1892. He was appointed one of the visiting medical officers of the Belfast Workhouse Infirmary in 1899, and was in charge of the surgical work. In this, as in everything else, he was actuated by the highest principles and ideals. He was conscientious and methodical to a fault, and his capacity for painstaking attention to detail made him one of the best teachers of the Belfast school. He was of a quiet and retiring disposition, and had not many intimate friends, but those he had regarded him with real affection, while all with whom he came in contact respected and admired his high character.

JAMES EDWARD BROGDEN, L.R.C.S., L.R.C.P.Ed.' L.F.P.S.Glas.

The death occurred at his residence in Cardiff, on Saturday week, of Dr. J. E. Brogden, after a long illness. The deceased was a student at Edinburgh and Glasgow, and took his degrees in 1887. He also studied at the London hospitals, and has practised in Cardiff for many years. Dr. Brogden was an ardent Churchman, but took little active part in public matters. He leaves a widow and two sons, one of whom is in business in London.

ROBERT WATSON, L.F.P.S.Glasg., LATE OF ROCHDALE.

We regret to record the sudden death of Mr. Robert Watson, who gave up practice at Rochdale two months ago and retired to Thornton, near Blackpool, which took place on Sunday while walking with his wife at Cleveleys. Having said to his wife, " Good-bye, my love," he immediately fell to the ground and expired. He was medically educated at Glasgow University, and took his diploma in 1863.

Literature.

CLINICAL DIAGNOSIS. (*a*)

The growing importance of hæmatology as a guide to clinical diagnosis is shown by the prominent position and ample space accorded to it in this standard treatise. No doubt the technique is, in many instances, beyond the scope of the average busy practitioner, but it is nevertheless highly desirable that he should learn to recognise the significance of these blood changes, because the actual research can be delegated to the specialist. So rapid is progress in this direction that the whole chapter has had to be re-written and considerably amplified in order to embody the most recent data. This chapter contains some beautiful coloured plates of microscopical appearances—so necessary in this department of clinical research—together with drawings of the various apparatus required.

Having discussed the chemistry and bacteriology

(*a*) " Clinical Diagnosis." By Rudolf von Jaksch, M.D., *Professor of* Special Pathology and Therapeutics, Director of the Medical Clinic in the German University of Prague, &c. Edited by Archibald E. Garrod, M.A., M.D., F.R.C.P., Assistant Physician to, and Lecturer on Chemical Pathology at, St. Bartholomew's Hospital, &c. Fifth English edition. 172 illustrations. London : Ch. Griffin and Co., 1905. Price 24s. net.

of the mouth and nose, the author takes up the examination of the sputum—another wide field of observation. In the chapter on the gastric juice and vomit special attention is devoted to the determination of the proportion of free hydrochloric acid in view of the fact that the absence of the free acid, or its presence in minute quantity, is, under certain circumstances, indicative of grave functional disturbances—its presence is even marked, excess being, functionally speaking, a venial offence. As a matter of fact, we are not yet in possession of trustworthy data to enable us to base an opinion on this reaction alone, and, as the author observes, "they must be weighed in conjunction with the other circumstances of the case." Of more practical import is the examination of vomited matter, for upon this examination depends the elucidation of many obscure problems in pathology. Many of the problems are of a toxicological character, and these are probably the most urgent and anxious.

No less than sixty pages are allotted to the chemical, physical and bacteriological examination of the fæces—a branch of clinical research more honoured in the breach than in the observance. Yet the amount of information to be obtained thereby is extraordinary, second only to the results of urinary analysis, which occupy nearly two hundred pages. The volume concludes with a chapter on "Methods of Bacteriological Research."

The translation, done for the most part by the late Dr. Cagney, is of high quality, but Dr. Garrod has enriched the work with many valuable additions drawn from his own extensive, almost unique, experience. The work is one of the greatest value as a working guide to the laboratory worker, and as a work of reference for the practitioner who aspires to something more than rule-of-thumb diagnosis.

SHORT PRACTICE OF MIDWIFERY FOR NURSES. (*a*)

The author, in his preface to this popular manual, "believes that it will be found to contain all that is required by a midwifery nurse." Well, we should rather fancy it did—*plus* a certain amount for which that humble maidservant of the profession can find no proper use—how to induce premature labour (*qua* abortion) for instance. Certainly no one can reproach the author with any sins of omission, and close scrutiny fails to discover any statement in dogma to which we feel justified in taking exception. It is one of the most practical books of the kind we have met with, is judiciously illustrated, and the text is couched in simple English, studiously purged of unnecessary technicalities.

KELLY ON THE VERMIFORM APPENDIX AND ITS DISEASES. (*b*)

It is really almost superfluous to endeavour to review at length Professor Kelly's magnificent work on the appendix, and furthermore, it is difficult to do so since there are so few works with which it can be compared. It might almost be said to stand in a class by itself and to constitute perhaps the finest monograph ever written. For those who have not as yet seen the book, we may say that it is a work of 827 pages, which are apportioned among thirty-five chapters; that it contains 399 illustrations in the text and three lithographic plates; and that both text and illustrations deal with their subject in a manner and on a scale which has not as yet been attempted elsewhere.

Professor Kelly commences his book with an interesting historical account of the origin of, and the different advances in, appendix surgery, and this occupies three chapters. In the four following chapters he deals at length with the anatomy of the appendix, after which its physiology and natural history follow. Chapter X. deals with the appearences usually presented by the appendix at autopsies, and Chapter XI. with its bacteriology. Then follow ten chapters dealing successively with pathology, etiology, clinical history, and diagnosis. The operative portion of the book then commences, and after a couple of chapters with the necessary preliminaries Chapters XXII. to XXVIII. deal more or less closely with operative procedures. Two most interesting chapters then follow, in which the relation between the appendix and gynæcological affections, pregnancy, labour and the puerperium, are considered. The next chapters deal with neoplasms and specific infections, and the last two chapters are occupied by a consideration of hernia of the appendix and the medico-legal aspects of appendicitis.

It is strange that, in spite of the amount of work which has been devoted to the study of the appendix and its diseases, we should still be so entirely dependent upon conjecture for the answer to such questions as "What are the functions of the appendix?" and "What are the causes of appendicitis?" We have said that Professor Kelly's work is unique amongst medical works, and surely it is also unique in another sense. It is unique to find a work of this size and magnificence dealing entirely with an organ of whose function we are ignorant, and for whose diseases we cannot find a cause.

THE HOURS FOR SLEEP AT SCHOOL. (*a*)

This octavo pamphlet of 32 pages—and diagram showing relation of sleep to age—deals with a question, or series of questions, of great importance, not only to the present and the coming generation, but to posterity in general and at large. The sleep of childhood and youth is a leading item in the development of the men and women who are to be; and in the present generation of unlimited civilisation and much-discussed universal peace, its enormous assets of the unfulfilled promises of former ages regarding the blessings of liberty, and universal education and manhood suffrage and "Rights of Man"—and "Rights of (the New) Woman"—with its unprecedented and unparalleled South African and Russo-Japanese wars, and the recent sudden awakening of this country to the fact that we are not only getting outrun by the other nations in the march of intellect and mechanical skill, that we have actually allowed ourselves to settle down into a sinking morass of "*physical deterioration*" (with which some would even join up *mental*)—in presence of this chaotic mass of contradictory opinions and doctrines and promises—we are recalled to a plain matter-of-fact discussion of the value of the proper management of what the rude forefathers of the hamlet have never failed, we believe, to recognise at its true value, the peaceful and restful sleep of the growing human being. It has become refreshing, indeed, to be called off once in a way from the endless chase of the protean and ubiquitious microbe to a casual discussion of one of the most important and ever necessary physiological needs of animal existence. The author deals with his subject so well and wisely that we recommend all our readers to go and examine his pages for themselves. Whatever doubts may be raised regarding the omnipotence of bacteria in disease, there can be no question of the indispensability of sleep both in sickness and in health.

THE MEDICAL DISEASES OF EGYPT. (*b*).

Nearly all parts of the vast "Dark Continent" just now offer special attractions to all sections of the British public in general. And nearly all section of the—till quite recently—correspondingly mystical *terra incognita* of tropical medicine present special

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(a) "A Short Practice of Midwifery for Nurses." By Henry Jellett, M.D., F.R.C.P.I. Gynæcological and Obstetric Physician to Dr. Steevens' Hospital, Dublin, &c. Second edition. Price 6s. 6d. net. London: J. and A. Churchill. 1905.

(b) "The Vermiform Appendix and its Diseases." By Howard A. Kelly and E. Hurdon. Philadelphia: W. B. Saunders and Co.

(a) "On the Hours of Sleep in Public Schools." Based on an Inquiry into the Arrangements existing in Forty of the Great Public Schools in England, and others in the U.S.A. A Paper read before the Association on May 11th, 1905." By T. D. Acland, M.A., M.D.Oxon. F.R.C.P., Physician to St. Thomas' Hospital. London: J. and A. Churchill, 1905. Price 1s.

(b) "The Medical Diseases of Egypt." By F. M. Sandwith, M.D., F.R.C.P., Consulting Physician to H.M. the Khedive, and to Kasr-el-ainy Hospital, Cairo; Lecturer at the London School of Tropical Medicine. Part I. London: Henry Kimpton, 1905.

interest to all progressive members of our profession in the opening years of the twentieth century. Accordingly, Dr. Sandwith's volume attracts by each of its poles.

There existed a very wide vacancy indeed in that compartment of medical literature which Dr. Sandwith has now undertaken to fill. As he points out in his preface, it is more than half a century since his "German predecessors, Bruner and Griesinger, wrote their works on Egyptian diseases, and since that time no one has published in any language a systematic book upon medicine as seen in Egypt, though several valuable monographs have appeared relating to many individual diseases." The time and opportunity have been most propitious to our author's undertaking, and he has made excellent use thereof.. The first instalment includes: "Medical History of Egypt," "Introduction to Infectious Diseases," "Typhus," "Relapsing Fever," "Enteric Fever," "Mediterranean Fever," "Simple Continued Fever," "Infectious Jaundice," "Scarlet Fever," "Measles," "Rubella," "Small-pox," "Inoculation and Vaccination," "Chicken-pox," "Mumps," "Whooping Cough," "Glandular Fever," "Influenza," "Plague," "Bilharziosis," "Ankylostomiasis," "Pellagra,"—Index, which might have been expanded with advantage to the practitioner who requires to consult the text at odd and uncertain times.

There are many items of interesting information here found under the names of those diseases which are not the special perquisites of tropical residence. The accounts of bilharziosis, ankylostomiasis, and pellagra—diseases of which our knowledge in this part of the world is so very usually second-hand—will well repay the attentive perusal of every reader. We will not attempt to criticise these sections; we have ourselves derived too much profit and pleasure therefrom; so we conclude by cordially thanking Dr. Sandwith for the valuable store of interesting information which he has placed at our disposal.

PHYSICAL CHEMISTRY. (*a*)

IT is perhaps not at all strange that physical chemistry occupies no place in the affections of the average student, yet a knowledge of the principles of the same would enable him to understand many of those facts in chemistry and biology that at present he takes for granted without worrying in the slightest as to the means by which these theories have been proved.

The volume before us represents a course of seven lectures delivered in the University of Birmingham in "the hope of encouraging and facilitating a more systematic and thorough study of physical chemistry on the part of students of medicine and biology." It is not a book to skim, and to appreciate it requires a thoughtful reader who is capable of a fair amount of application to the work, but to such an one the book should transform physical chemistry from a *terra incognita* into a realm of which he begins to see the beauty, and he will see that a further knowledge of the subject will help him to appreciate biology better and what is of still greater importance, will suggest opportunities for research that will enrich the science of medicine, which but for his acquaintance with physical chemistry would never have been conceived by him.

LUFF'S MANUAL OF CHEMISTRY. (*b*)

THIS volume is one of Messrs. Cassell's red-covered Manuals, which are so well known to students. It has been revised, brought up to date, and such additions as methods for the determination of boiling and melting points have been made. To the practical part a short account of Volumetric Analysis has been added. The authors have succeeded in rendering as clear in print as such subjects can well be made those parts of the science which render chemistry distasteful to most students. We may instance the chapters on Formulæ, Chemical Equations, and Quantivalence as portions likely to be especially acceptable to students. A careful perusal of these chapters will obviate what many students look on as a necessity—that they should grope along without having a grip of such subjects. The composition of many drugs, such as heroin and mesotan, which have recently come into use are given. The chapter on "Problems" gives many examples of such chemical sums as a student requires, with full explanations of the method employed in each, which cannot but be very welcome.

Laboratory Notes.

MOLLER'S HYDROXYL-FREE COD-LIVER OIL

THERE must be a very large number of people who would benefit to a great degree by the use of cod-liver oil, who are restrained from taking it by the nauseous taste and unpleasant eructations which have come to be looked on as the necessary accompaniments of the oil. Messrs. Peter Möller, Ltd., by the introduction of their Hydroxyl-Free Cod Liver Oil, have placed in the hands of medical men a most excellent and valuable preparation which is almost free from taste, limpid in character, and, what is a still greater charm, does not cause the objectionable "repeatings" we are so familiar with in certain brands. This desirable consummation has been accomplished by conducting the operations of preparation from start to finish in an atmosphere of carbon dioxide, thus excluding the atmospheric oxygen, which apparently is the cause of the usual objectionable characters. We can testify to the fact that when ordinary oils are only taken under protest, Möller's is accepted without a murmur. The analytical data show it to be free from other fish oils, now so commonly used as adulterants, and this fact alone is sufficient to recommend the oil. It gives the violet colour with sulphuric acid (B.P. test), and also a much more valuable indication, and that is, a faint salmon pink coloration with a mixture of sulphuric and nitric acids. The specific gravity is 0·9268; the free acidity 0·30 per cent. (as oleic acid), and the iodine absorption 158·4 per cent.

THE STANDARDISATION OF DRUGS.

THE standardisation of preparations of drugs is regarded nowadays as an indispensable adjunct to the manufacturing chemist's duties. The difficulty, however, of doing so is that the chemistry of many important drugs is yet so little understood that quantitative tests cannot be framed. In a paper read by Dr. W. E. Dixon at the British Pharmaceutical Conference in July, certain biological tests for certain drugs were suggested, and with commendable enterprise Messrs. Evans, Gadd and Co., Ltd., of Exeter, the well-known manufacturing chemists, have decided to send preparations presenting chemical difficulties to Dr. Dixon for biological standardisation. Tinctures of strophanthus and Squill, which answer to these tests, are now prepared by them, and we are sure that medical men will be glad to avail themselves of this extra security when opportunity offers.

AN IMPROVED AID TO INFANT FEEDING.

Most of our readers are doubtless acquainted with Messrs. Allen and Hanbury's admirable feeding-bottle for infants. This bottle is designed on simple and intelligent lines, and is not excelled by any other that we know of. One of its drawbacks, which it shares with all other feeding-bottles, is the liability of the teat to be pulled off the neck by the child when feeding. This slight defect has just been remedied by the invention by that firm of a special teat which is so made as automatically to cling to the neck of the bottle. There is no special fastening, but merely an alteration in the shape and construction of the teat. The invention commends itself to us.

(*a*) "Physical Chemistry and its Applications in Medical and Biological Science." By Alex. Findlay, M.A., Ph.D., D.Sc., Lecturer on Physical Chemistry, University of Birmingham. Pp. 68. Price 2s. net. Lonon: Longmans, Green and Co. 1905.

(*b*) "A Manual of Chemistry, Inorganic and Organic." By Arthur P. Luff, M.D., B.Sc., L.R.C.P., F.I.C., Physician to St. Mary's Hospital, and Frederick James M. Page, B.Sci F.I.C. A.R.S.M., Lecturer on Chemistry and Physics to London Hospital Medical College. Pp. 555—xb. 43 engravings. Third Edition, revised throughout, price 7s. 6d. London: Cassell andCompany, Ltd.

Medical News.

The Virchow Memorial.

THE Committee appointed to carry the proposal of a memorial to Rudolf Virchow into execution has now a sum of £4,000 at his disposal. Of this amount, £1,800 has been contributed by subscribers and £2,200 by the city of Berlin. Three prizes, of the value respectively of £150, £100, and £50, are offered for the best design of a memorial. Drawings must be sent in before April, 1906.

International Congress of Anthropology.

THE International Congress of Prehistoric Anthropology and Archæology will hold its thirteenth meeting at Monaco, under the patronage of Prince Albert the First, from April 16th to 21st, 1906. The important discoveries made in the territory of Monaco, especially those due to the initiative of the Prince himself, will lend special interest to the meeting. Excursions are being organised to the celebrated caves of Baoussé-Roussé, and to other places of prehistoric interest. Detailed information as to the Congress may be obtained on application to the General Secretary, Dr. Verneau, 61, Rue de Buffon, Paris.

International Congress of Criminal Anthropology.

THE sixth International Congress of Criminal Anthropology will open at Turin on April 28th, 1906. The following questions are proposed for discussion, and the communications presented will, as far as possible, be grouped round these as central themes: (1) The treatment of juvenile criminality according to the principles of criminal anthropology, to be introduced by M. von Hamel; (2) the treatment of female criminality, to be introduced by Dr. Pauline Tarnowsky; (3) the relations of economic conditions to criminality, to be introduced by Professor Kurella; (4) the equivalence of the various forms of sexual psychopathies and criminality, to be introduced by Professor C. Lombroso; (5) criminal anthropology in police organisation, to be introduced by Professor Ottolenghi; (6) the psychological value of evidence, to be introduced by Dr. Brusa; (7) prophylaxis and treatment of crime, to be introduced by Dr. Ferri; (8) establishments for the perpetual detention of criminals declared to be irresponsible on account of mental defect, to be introduced by Professor Garofalo.

Annual Christmas Excursion to the Riviera.

THOSE of our readers who contemplate a few days' relaxation will be interested to learn that the South Eastern and Chatham Railway has announced that a special train, composed of first and second class lavatory carriages and a restaurant car will leave Boulogne for Marseilles, Cannes, Grasse, Nice, Mentone, Monte Carlo, and other stations on the Riviera, on Friday, December 22nd, in connection with a special express train from Charing Cross Station at 2.15 p.m., by the short sea routs *via* Folkestone and Boulogne. The reduced return fares from London to any of the above Riviera Stations will be:—First class, £9 12s.; second class, £6 12s.; and passengers will be able to return on any day, either *via* Calais or Boulogne, up to January 30th, inclusive. The sea passage from Folkestone to Boulogne will be performed by one of the South Eastern and Chatham Company's new turbine steamers in about 80 minutes.

North London or University College Hospital.

AN urgent appeal signed by the Duke of Bedford as president, and Lord Monkswell as treasurer, is being circulated, calling attention to the pressing needs of this hospital through the completion of the new building, by the munificence of the late Sir Blundell Maple, Bart., and the opening in September last of eighty-six additional beds and cots, which it is hoped will admit annually some 1,200 additional patients. Regret is expressed that during the past year it was found necessary to sell out stock to the extent of about £5,000 to provide funds for maintenance and furnishing the new building, consequently there are pressing grounds for issuing this appeal, the response to which will, we trust, be liberal.

Pass Lists.

University of London.

THE following is an official list of candidates who passed the recent M.B., B.S., Examination, arranged in alphabetical order:—

Honours.—Richard William Allen (*a*), Reginald Henry Miller (*a*), Percy Strickland Mills (*d*), Robert Milne (*a*), Arthur Boniface O'Brien (*d*, *e*), John Bart Rous (*a*), Donald Platt Sutherland (*a*, *b*, *e*, University Medal), Arthur Denham White (*d*), Sidney Rawson Wilson, (*d*).

(*a*) Distinguished in Medicine.

(*b*) Distinguished in Pathology.

(*c*) Distinguished in Forensic Medicine and Hygiene.

(*d*) Distinguished in Surgery.

(*e*) Distinguished in Midwifery and Diseases of Women.

Pass.—George Cuthbert Adeney, Herbert Ainscow, Francis Barlow Ambler, Arthur William Baker, Frederic Barker, William Henry Barnett, John Aaron Berlyn, Valentine Henry Blake, William Brown Clark, Millais Culpin, Delia Davies, Henry De Vine, Douglas Edward Finlay, Allan Rigden Finn, Thomas Evans Francis, Florence Erin Gubb, Dorothy Christian Hare, Edward Montague Harrison, Walter Dixon Hartley, Herbert Geo. Murdoch Henry, Cecil Hugh M. Hughes, Hyman Isaacs, Alfred Gwilym Jones, Charlotte Alice King, Stephen March Lawrence, Brinley Richard Lloyd, Edward Cronin Lowe, Horace Sidney Matson, Wilfrid Ombler Meek, Edward Farminer Milton, John Hobart Nixon, John Morgan O'Meara, Wilfred Jas. Hussey Pinniger, Thos. Phare Puddicombe, Robert Leslie Ridge, Chas. Chapman Rushton, Philip Henry Seal, David Lindley Sewell, Frederick Augustus Sharpe, Eric Bellingham Smith, Malcolm Wm. Stewt. Smith, Olive Bertha Smith, George Alick Soltau, Archibald Alfred Sutcliff, Claude Edward Tangye, B.A., Herbert Andrew Watney, Edith Waine T. Watts, Walter Welchman, Thomas Francis Wilson.

B.S. Examination (for students who graduated in Medicine in or before May, 1904):—

Honours.—M. A. M. Fitzmaurice-Kelly (University Medal), Harold Chas. Corry Mann.

Pass.—Ruth Levi Bensusan, Athelstan Jasper Blaxland, Arthur Chas. Haslam, M.D., Maurice Louisson, Ernest Edgar Maples, Chas. Pye-Smith.

Trinity College, Dublin.

THE following candidates passed the Final in Midwifery at Michaelmas, 1905:—Samuel G. S. Haughton, Thomas H. Peyton, John C. P. Beatty and Basil G. Brooke (equal), Montgomery W. Ferguson, Percy B. Egan, Richard A. Connell, John D. Sands, Francis R. Coppinger, Daniel M. Corbett and Hercules J. Knox (equal), James M. Harold, Edward D. Atwell and William I. Thompson, Herbert J. Wright, (equal) Cyril H. M'Comas, George S. Walton.

IT is reported that anthrax has broken out at Magdalen Laver and three other places in the county of Essex.

A STRONG committee has been formed to erect a sanatorium for the county of Middlesex. It is intended to keep the cost of the building down to the lowest possible point, and the 100 beds in view will all be covered by a capital inclusive expenditure of £30,000. County authorities have already promised to pay for a quarter of whatever beds are provided, and for the rest public subscriptions are sought. The Honorary Secretary, Colonel Gerard Clark, 8, Grange Park, Ealing, is ready to receive donations, and also to supply any information that may be desired.

Notices to Correspondents, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, to avoid the practice of signing themselves "Reader," "Subscriber" "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

DR. T. S. C.—Communication came to hand as we were at press. The subject will be referred to in our next.

THE D.P.H. DIPLOMA.

A correspondent asks if it is absolutely necessary that candidates for appointments as health officers must possess the D.P.H. Our reply is that, except in cases of very minor importance, the possession of this diploma has gradually become a necessity. On reference to our advertising columns it will be seen that the Cambridge Local authority is requesting applications for the post of medical officer of health for the Borough at a salary £450 per annum, but candidates must hold this diploma.

DR. O. H.—We hope to find room for your communication next week. We regret the delay, which has been unavoidable on account of the increasing demands on our space.

COL. W. G. will find the notice in our present issue; it was crowded out last week.

MEDICINE AND ADVICE FOR FOURPENCE.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The following appeared in the *Daily Telegraph*:—

At an inquest held on a baby by Mr. George E. Hilleary, at Canning Town, it transpired that the doctor in the case charges but 4d. for *advice* and *medicine*. He has a fairly large practice, and has fixed his price at 4d. because he suggests the very poor often suffer for want of the usual fee. The baby died from pneumonia, and its mother said that after it had been ill for two days she took it to the doctor "as soon as she could spare the fourpence."

What are we coming to? The 6d. doctor is bad enough, but 4d. oh!! What about the term, "infamous conduct"? and to supply medicine as well! Street organs will pay better. The Medical Council is, according to my view, of no good to the profession whatever. Medical advice is now advertised by newspapers for 1d., Doctors' advice and medicine is down to 4d.; the name of doctor dragged through the mire into the bargain; while the chemist gets 1s. 6d. for a bottle with his advice thrown in.—ICHABOD.

DR. EWENS.—We hope to find space for your case in our next.

R. J. WILSON (Cornwall).—(1) The injection of saline fluid into the veins is a valuable treatment in many cases of shock. Where time is an object it may be injected into the rectum. (2) Many instances are on record of belladonna absorption through the broken skin, with more or less serious consequences.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, DECEMBER 13th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus).—8.30 p.m. Papers:—Mr. H. Lett: Surgical Aspects of the Colon.—Mr. J. T. Fox: Considerations on the Management of the Large Intestine.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street Cavendish Square, W.).—5.15 p.m. Meeting.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Mr. H. T. Butlin: Carcinoma is a Parasitic Disease. (Bradshaw Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. L. Cheatle: Clinique. (Surgical). 5.15 p.m. Mr. H. L. Barnard: Diseases of the Gall Bladder and Bile Ducts.

THURSDAY, DECEMBER 14th.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture:—Mr. H. T. Mark: Moral Intuition and Common Sense—a Study of Original or Inherited Moral Capacity. (Arranged by the British Child Study Association.)

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Cases and Specimens will be shown by Mr. L Johnson, Mr. G. W. Roll, Mr. M. Hepburn, Mr. N. C. Ridley, Mr. N. B. Harman, Mr. J. H. Parsons, and Mr. C. Blair. 8.30 p.m. Papers:—Dr. D. M. Mackay: Light Sense in Strabismus—Mr. F. R. Cross: Kroenlein's Operation for Tumours of the Orbit.—Mr. S. Mayou: On Cyclops.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m Dr. C. Mercier: Signs of Insanity.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Alopecia: I., Areata; II., Trichorrhexis; III., Seborrhœa. (Chesterfield Lecture.)

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Lecture: Mr. H. Barwell: The Nose and Throat in Chest Diseases. (Lecture II.) (Post-Graduate Course.)

FRIDAY, DECEMBER 15th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos St., Cavendish Square, W.).—5.30 p.m. Discussion on Pleural Effusions Serous and Purulent—(1) Pathology, Dr. J. G. Emanuel (Birmingham); (2) Symptomatology, Dr. G. A. Sutherland; (3) Treatment, Dr. E. Hobhouse (Brighton), and Mr. P. L. Mummery, and continued by Mr. L. S. Dudgeon, Dr. W. J. S. Bythell (Manchester), Dr. W. Ewart, Dr. G. Carpenter, and others.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper:—Dr. A. Newsholme: The Relative Importance of the Constituent Factors involved in the Control of Pulmonary Tuberculosis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. N. Maclehose: Clinique. (Eye.)

TUESDAY, DECEMBER 19th.

THERAPEUTICAL SOCIETY (Apothecaries' Hall, Blackfriars)—4.30 p.m. Mr. H. Wippell Gadd, F.I.C., F.C.S., on the Chemistry and Pharmacy of the leaves of Viola odorato. Dr. William Bain: On Cholelithiasis, and its medical treatment.

Vacancies.

Cancer Wing of the Middlesex Hospital.—Medical Officer and Registrar. Salary £100 per annum, with board and lodging. Applications to F. Clare Melhado, Secretary-Superintendent.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Casualty Medical Officer. Salary £200 per annum, with lunch. Applications to the Secretary.

Manchester Children's Hospital, Pendlebury, near Manchester.—Visiting Surgeon. Salary £100 per annum. Applications to the Secretary

Tropical Diseases.—Princess Christian Hospital, Freetown, Sierra Leone. Medical Officer. Salary £250 per annum, with rooms. Applications, with references, to the Rev. Arthur Sinker, St. Anne's Vicarage, Bermondsey, S.E.

Infirmary of the Wandsworth Union, St. John's Hill, near Clapham Junction.—Junior Assistant Medical Officer. Salary £100 per annum, board, lodging, and washing. Applications to Medical Superintendent.

Bournemouth Royal Victoria Hospital.—House Surgeon. Salary £100 per annum, with board, lodging and laundry. Applications to the Secretary.

University of London.—Professorship of Protozoology. Salary £700 per annum. Applications to Arthur W. Rucker, Principal, the University of London, South Kensington, S.W.

Salford Royal Hospital.—
Senior House Surgeon. Salary £110 per annum.
House Physician. Salary £100 per annum.
Junior House Surgeon. Salary £90 per annum.
Applications to George Ruddle, Secretary and Medical Superintendent.

Borough of Cambridge.—Medical Officer of Health. Salary £450 per annum. Applications to J. E. L. Whitehead, Town Clerk, Guildhall. (See Advt.)

Appointments.

COX, FRANKLIN, L.R.C.P.Lond., M.R.C.S., Medical Officer and Public Vaccinator for the Radstock District by the Clutton (Somerset) Board of Guardians.

MIALL, CHARLES L'OSTE, L.R.C.P.Lond., M.R.C.S., Medical Officer and Public Vaccinator for the Paulton District by the Clutton (Somerset) Board of Guardians.

POLLARD, GEORGE SAMUEL, L.R.C.P.Edin., M.R.C.S., Medical Officer and Public Vaccinator for the Midsomer Norton District by the Clutton (Somerset) Board of Guardians.

RICHARDSON, ARTHUR WILLIAM CECIL, M.B.Lond., Medical Officer to the Bristol Dispensary.

RIMELL, ALFRED TOM, M.D.Durh., Medical Officer and Public Vaccinator to the Third, Fourth and Tenth Districts of the Tendring Union, Essex.

SUTHERLAND, DAVID, M.B., B.S.Edin., Medical Officer to the Worksop Dispensary and Victoria Hospital.

WALSH, LESLIE H., M.D., B.S.Durh., Physician to Bellotts Mineral Water Hospital. Bath.

Births.

MCKAIG.—On Dec. 7th, at Milford Hill, Salisbury, Dr. Mary Churchill (née Pepper), wife of Andrew McKaig, M.B., of a daughter.

Marriages.

BRODIE—JACOBS.—On Dec. 7th, at All Saints', Norfolk Square, W. Desborough Brodie, M.B., B.S., of Tetbury, Glos., second son of Robert Brodie, M.A., of Croydon, to Bessie Graham, youngest daughter of the late Hon. Justice Jacobs, C.M.G., of Sutton. Surrey.

DANIEL—THOMAS.—On Dec. 5th, at All Saints' Church, Edinburgh. Ronald Dalrymple Daniel, M.D., of Oulton Broad, Suffolk, and Fort View, County Wexford, to Vera, only daughter of Mrs. Arding Thomas, Ballymeanoch, Argyllshire.

DAWSON.—BOYD.—On Dec. 6th, at St. Luke's, West Norwood, Ernest Rumley Dawson, L.R.C.P., M.R.C.S., of Leyton, son of Benjamin Dawson, B.A.Lond., formerly of Hampstead, to Alice, only daughter of Charles Boyd, of West Norwood.

UNDERHILL—MEREDITH.—On Dec. 7th, at Christ Church, Gipsy Hill, London, Thomas Hill Underhill, M.B., M.C.H., youngest son of Thomas Underhill, M.D., J.P., of West Bromwich, to May Sarah, third daughter of the late Henry F. Meredith, of Upper Norwood.

Deaths.

LOUGH.—On Dec. 9th, at 25 Duncan Terrace, Islington, London. John Joseph Lough, M.B., T.C.D.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, DECEMBER 20, 1905. No. 25.

Original Communications.

SOME
PRACTICAL OBSERVATIONS UPON MENINGITIS.—II. (*a*)

By F. J. POYNTON, M.D., F.R.C.P.LOND.,

Assistant Physician to University College Hospital, and to the Hospital for Sick Children, Great Ormond Street, London.

In my first paper I pointed out how closely acute infantile paralysis may simulate meningitis. Cerebral symptoms in whooping-cough may also simulate tuberculous meningitis very closely, as in the case of a girl in whom a convulsion occurred with almost every paroxysm of coughing.

The absence of some cardinal symptom is a frequent cause of difficulty in the diagnosis of tuberculous meningitis, and one finds oneself wondering whether headache can be absent, or vomiting, or a cranial nerve paralysis. There is no doubt that any one of these symptoms may be wanting, sometimes throughout the illness, often until the diagnosis has become only too obvious.

A sudden attack of convulsions as the first definite symptom was once very closely brought home to me when a house-physician. A child had been taken to the waiting-room as slightly ailing, and the mother had left the room to give the history of the illness. Suddenly the child was seized with convulsions, and in half an hour was all but dead; the mother, who had been sent for, accused me of chloroforming her child, or otherwise damaging it, for she had left it apparently almost healthy. This child rallied, but never became sensible again, and died three weeks later. Surgeons on the other hand are well acquainted with the insidious onset of tuberculous meningitis, which sometimes may occur after operations. A slight attack of vomiting attributed to the chloroform, a slight squint, and a deepening coma may find every one taken unaware until the patient is clearly moribund.

With elderly people tuberculous meningitis may also be most puzzling. Thus, for example, constant headache and mental aberration were the prominent symptoms in two such cases occurring over the age of 50.

Still more confusing and most deceptive are those cases which occur in young anæmic and emotional women. By a strange coincidence, I saw two of these cases within a month, and in both wild excitement at night had first alarmed the friends, and one of these patients in her excitement had torn up her clothes. Both these cases had been mistaken for hysteria, and both died within a fortnight. It is noteworthy that in both also, when they were first seen, there had been headache and fever, a combination which must always suggest caution.

The nervous symptoms in babies associated with teething and with slight middle-ear disease are sometimes excessively puzzling. It is then that special care is needed in judging of the relative value of symptoms. A definite paralysis such as ptosis, for example, or divergent strabismus, is far more reliable proof of meningitis than is retraction of the head, screaming, or vomiting. Irregular sighing breathing means more than aimless movements of the eyes, and optic neuritis far outweighs the tache cerebrale.

These numerous difficulties lead me to speak of some of the newer methods in diagnosis. Kernig's sign is one, and has attracted great attention.

A method of eliciting it is as follows:—With the patient recumbent, the leg is extended on the thigh and the thigh is then flexed on the abdomen, the tension on the nerve roots of the great sciatic produces instant flexion of the knee upon thigh on account of the meningeal inflammation. It is a sign much valued in cerebro-spinal fever. I have, however, been disappointed with it in tuberculous meningitis.

Another important method which has come into great favour of late is lumbar puncture. It is not difficult. The patient is placed on the right side, and the back arched with its convexity towards the operator. An excellent landmark is a line drawn across from the top of one posterior iliac spine to the other. The next veretebral spine above this line is marked, and the needle inserted immediately above it, and about a quarter of an inch to one side of it. Some with great experience prefer the middle line. Local anæsthesia, or a whiff or two of chloroform for a child, is sufficient. The needle in the case of a child will pass, inward about one and a half inches before reaching the canal, while in an adult the distance will be about two inches.

The value of this method in treatment is very limited, but we have recently had the weighty opinion of Professor Osler that it may afford much relief when there is evidence of acute tension in the cerebro-spinal system, as shown by urgent headache and vomiting or rapid coma, and in infants by a very tense fontanelle.

Its use is more extensive in diagnosis. I have never myself seen any evil consequences, and it is now used so frequently that it hardly seems that there can be any special risk about this procedure. I have, however, I confess, heard ugly rumours of ill consequences, such as collapse, but cannot substantiate these from personal observation. Its value is not, however, comparable to an exploration of the pleura. We know if we explore a pleural cavity that we shall often not only clear up a diagnosis, but also get a direct lead in treatment, of lumbar puncture the same can hardly be said. The diagnostic value also depends upon considerable technical skill in the making of cultures and films, and in the detection of micro-organisms, a point very clearly brought out by Dr. Horder in the recent discussion on meningitis at the Leicester Meeting. It is a method that personally I do not employ, unless the uncertainty of the case needs every expedient for its elucidation. Operative treatment in tuberculous meningitis is recognised at present as inadmissible, but in post-basic meningitis the possibility of treating the hydrocephalus by drainage has been repeatedly advocated and the operation has been frequently done.

(*a*) Read before the Thanet Division of the B.M.A., Sept. 26th' 905.

The lateral ventricles have been drained, and in one classical case of Lees and Ballance which I had the good fortune to see, a remarkable recovery ensued. Other cases have been recorded, but the usual result is complete failure. It has been my misfortune to have had many of these cases at one time or another under my care, but up to the present I have never seen any operative success with them. Whether taken early or late they have all died. The most successful case lived for some months, but I do not think there was any real improvement, or that the tube had kept its position in the brain, and acted as a drain. We know the pitiful state of hydrocephalic children if they are left. And it seems certain that if you want success, the case must be taken early, but the risk is tremendous. The parents are often enough clamorous for the operation, and there is no denying the fact that some remarkable results have been obtained, and I suppose if the parents thoroughly understand the terrible risk of the operation this should be sufficient to encourage us to hope that in each carefully chosen case we may be successful. Cases of post-basic meningitis sometimes, however, recover in a remarkable way without operation ; but even then sometimes they die in the near future quite unexpectedly and suddenly. The disease itself is at the present time looked upon as of the same nature as the cerebro-spinal fever of which we have recently heard so much from America and Silesia. The diplococcus demonstrated by Dr. Still is now thought to be identical with the meningococcus of Weischlebaum, the cause of cerebro-spinal fever. I doubt the actual identity of these two diseases.

It is interesting, I think, although in London we frequently see post-basic meningitis, that up to the present this year we have had nothing of the nature of an epidemic of cerebro-spinal fever.

Post-basic meningitis, though often of long duration, is very fatal. Because there is recovery it seems and is more hopeful than the tuberculous form, but the recovery is sometimes very imperfect, and such traces are left as chronic hydrocephalus, blindness or deafness, epilepsy and idiocy or weak-mindedness. In judging of the severity of a case, vomiting, wasting, fever, and supervention of hydrocephalus are valuable guides. The onset may be most insidious. A slight convulsion, irritability, some rigidity of the neck, or abnormal movements of the eyeballs, with occasional vomiting may be the only symptoms, and these disappearing may leave only a mysterious wasting and fever. A remarkable complication is the occurrence of swelling around the joints. These swellings are usually periarticular, but I have seen, together with hydrocephalus, both knee-joints full of fluid. Such success as I have had in treatment has been by attention to minute details. Gaining rest by small doses of chloral and bromide, restraining sickness by peptonising the milk, and giving bismuth and alkalies. Relieving pain by small doses of opium, and treating constipation by the cautious use of mercurials and salines. I have already spoken of hydrocephalus.

Pneumococcal meningitis would seem to be invariably fatal, but the great difficulty in childhood is to ascertain when this meningitis is present. It may seem paradoxical, but cases which appear to be doomed to acute meningitis recover, and cases in which meningitis is not even thought of, die from this cause.

Thus, for example, an only child, æt. 1 year and 4 months, whom I saw with Dr. Chatterton, of Hornsey, had been ailing and fretful for a month, and five days before I saw him had become suddenly worse with screaming, vomiting, constipation and extreme illness.

This child lay in its cot unconscious to its parents, with a temperature of 100°. There was sharp screaming at intervals and the neck was stiff. On the other hand, there was rapid and grunting breathing, there were no paralyses, and Kernig's symptom was absent. We found a little patch of tubular breathing at the lower angle of the right scapula.

The infant seemed certain to die from a pneumococcal infection of lung and meninges, but it made a rapid and perfect recovery in a week from that time.

On the other hand, marasmic children with bronchopneumonia die of suppurative meningitis without showing a single symptom except possibly some screaming and then coma. Such cases are almost invariably mistaken for tuberculosis of the lungs or are overlooked. A little girl in University College Hospital last month who died with empyema, malignant endocarditis, suppurative pericarditis, and meningitis, showed no symptom except vomiting and a terminal delirium, both of which could have been explained by the heart disease.

Time will not permit me to enter at length upon the sequelæ of meningitis. Hydrocephalus, blindness, deafness, idiocy and epilepsy have all been incidentally mentioned. Sometimes remarkable functional symptoms appear, and there is difficulty in ascertaining to what extent we are dealing with symptoms of organic disease, or with functional disturbances.

For example, a young man, æt. 17, had a severe attack of erysipelas of the scalp in October, 1897, which infected the meninges, as shown by double optic neuritis, severe headache, mental hebetude, and vomiting. From this he made a remarkable recovery, but a month later, after becoming quite convalescent, headache and vomiting reappeared and he then lost power in his legs and control over his bladder. In this state he remained for close upon two years, and then made a complete recovery under persistent Faradism.

It is impossible to believe in this case that the majority of those serious symptoms were the result of organic disease, for the recovery was both rapid and complete, and further was apparently permanent, for I saw this patient a year later in admirable health and hard at work again.

Epilepsy is recognised as a sequela of many organic diseases of the brain. It, for example, will be met with in some cases of recovery from post-basal meningitis, and also after polio-encephalitis. The development of this epilepsy may be delayed for a long period of time ; it may be *petit mal* or *grand mal*, or both combined. On the other hand, the epileptic condition may supervene rapidly and the condition of the patient can hardly be then called one of recovery.

Epilepsy, too, is sometimes an evidence of congenital syphilitic meningitis—the acquired syphilitic cerebral disease in adults is a too important and wide subject to touch upon now. Those curious coincidences of hospital practice have brought two of these cases prominently before my notice recently. Both were boys, both developed epilepsy about seven years of age, in both after about eighteen months I detected enlargement of the liver, and one developed ascites. Both died with obscure cerebral symptoms complicating the epilepsy, and both had cirrhotic livers. Such cases have been described by Dr. Ormerod. The thickening of the pia mater was well shown in the brain of the second case, and the vessels at the base were rigid and unduly patent.

In such cases if one can only detect them, mercurials and iodides are clearly needed in addition to the bromides for the treatment of the epileptic state.

An important after result of meningitis is a permanent weakness of the mind. Thus a child, æt. 12, who had suffered from posterior basic meningitis at six months and was then in the Great Ormond Street Hospital, with retraction of the head, fever, blindness, and other symptoms of the disease, is now a big, well-nourished girl, with her sight restored, enjoying excellent health, but quite feeble-minded, though good-tempered and able to carry a simple message. In cases such as these it is very probable that there is some degree of permanent hydrocephalus.

Finally, I am afraid that up to the present I have never seen any recognisable improvement from serum treatment in tuberculous meningitis, and Wright's method of vaccination is not, as he has himself insisted, suitable in its present state of development for use in acute tuberculous meningitis.

A CASE OF

DIPHTHERITIC HEMIPLEGIA:

WITH COMMENTARY.

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A boy, æt. 6, was admitted to hospital on Nov. 21st, 1904, for diphtheria. He had been ill six days. The extensive faucial œdema and exudation, cervical adenopathy, rhinorrhœa, and oral fœtor testified to the severity of the attack. There was a cloud of albumin in the urine, which persisted till the forty-first day of the disease. On admission and on the two following days he received three doses of antitoxin of 24,000 units each. The throat was syringed four-hourly with a lotion containing potassium chlorate and myrrh, and he was given 5 minims of adrenalin solution (Parke Davis) in a drachm of aqua camphoræ two-hourly. On the 25th the voice was first found to be slightly nasal. The membrane had all gone from the fauces by the 26th, leaving extensive superficial necrosis of the mucosa of the tonsils, uvula, and soft palate.

The same day, on examination of the heart, which had hitherto been normal, the sounds were found to be very rapid and close together. The liver, which had been examined daily and hitherto shown no signs of enlargement, could now be felt one finger's breadth below the ribs. The voice was more decidedly nasal.

On Nov. 27th, the pulses were weak and unequal. The apex beat of the heart was close to the nipple line, and there was a triple rhythm. The liver was now one and a half fingers' breadth below the ribs. On Nov. 28th, general urticuria developed, fresh crops appearing during the next two days. The liver was two fingers' breadth below the ribs. The heart and pulses were as before.

On Nov. 29th, the fourteenth day of the disease, the patient vomited for the first time. The heart action was rapid. Triple rhythm with occasional irregularity was present. The apex beat was still in the nipple line. The liver was now three fingers' breadth below the ribs. Mouth feeds and medicine were stopped, and nutrients containing 4 ounces of peptonised milk and 15 minims of adrenalin solution were administered every four hours. The vomiting persisted, the pulses became weaker, the heart action more irregular, and the total amount of urine in the twenty-four hours fell to 3½ ounces.

On Dec. 3, the eighteenth day of the disease, 20 minims of tincture of belladonna and 20 grains of potassium bromide were substituted in alternate feeds for the adrenalin solution, which was omitted. The vomiting ceased, the enlargement of the liver began to subside, and the amount of urine increased, but the physical signs of the heart showed that the organ was considerably affected. As the vomiting had ceased, mouth feeds were resumed, consisting of whey, and bread and butter, and no further vomiting occurred.

On Dec. 7th, nothing was noted except that the child was very listless. The cardiac apex beat was in the nipple line, the action was very irregular, the sounds being of the nature of what Comby graphically calls *faux pas de cœur*. The enlargement of the liver had quite subsided. On the 8th, the twenty-third day of the disease, the peculiar appearance of the child and his inability to use his right arm made the nurse send for me. On arrival I found well-marked palsy of the right lower facial muscles and deviation of the tongue to the paralysed side. There was complete loss of power in the right upper limb. In the lower extremity the palsy was less complete. Motor aphasia existed. The knee-jerks were absent on both sides. Babinski's sign was present on the right side, the normal flexor response on the left. Ankle-clonus, which was first sought for the following day, was present, and could be elicited till Dec. 17th. The epigastric, abdominal, and cremasteric reflexes were deficient on the right, normal on the left side. Sensation did not appear to be affected. The urine, as hitherto, contained a cloud of albumin, but no sugar.

On Dec. 9th, the right foot and lower part of the leg were glossy and œdematous and the paralysis in the lower limb was more marked. Spontaneous movements were not performed, but the leg was drawn up when the sole was tickled. On the 10th, the twenty-fifth day of the disease, paralysis of accommodation was observed. The heart was now normal. On the 14th, very slight spontaneous movement of the right foot was first noted. The upper limb was still in a state of flaccid palsy, and the aphasia persisted. The improvement in the motor condition of the lower limb continued until on Dec. 28th, he could move the right limb almost as well as the left. The great toe of the right foot was then found to give a flexor response, but not so well as on the left side.

On Dec. 23rd, the thirty-eighth day of the disease, the child first began to cough over drinks, but no difficulty in swallowing solids was noticed till the 29th, when salivation, pharyngeal gurgling, and choking indicated paralysis of the muscles of deglutition. Mouth feeding was therefore discontinued, and he was given 4 ounces of peptonised milk with 15 minims of belladonna by a nasal tube every four hours. The cot was raised to allow the excess of mucus and saliva which he could not swallow to drain through his nose. On Jan. 3rd, twenty-six days from the onset of the hemiplegia, slight spontaneous movement of the right arm at the shoulder was first noted, and from that date gradual improvement in its movements occurred, though independent movement of the fingers did not take place till Jan. 7th, 1905, by which time he had so far recovered his power of speech as to be able to say and sing several nursery rhymes. On Jan. 7th, the clearer sound of the voice and the absence of salivation from the mouth, and of escape of mucus and saliva through the nose, indicated that the pharyngeal palsy was passing off. Soft solids were at first given by the mouth, and by the 9th he was able to take ordinary food well.

On Jan. 11th, the fifty-seventh day of the disease, when he was first propped up in bed, the weakness of the neck muscles was shown by the head rolling from side to side or falling backwards. Massage of the back and of the affected limbs was employed and subsequently the faradic current as well. Facial paresis lasted till within a few days of his discharge. Deviation of the tongue to the right continued till Feb. 28th. On Jan. 21st, the first day he was allowed up in clothes, he could walk with support, but it was not till Feb. 1st, the seventy-eighth day of the disease that he could stand or walk by himself, even for a few steps. His gait at first in no way suggested previous unilateral loss of power, but was that characteristic of pronounced diphtheritic pseudo-tabes. As the ataxy passed away, some dragging of the right leg was noticeable, which continued, though with gradual improvement, till the time of his discharge. Mental impairment, to the existence of which in diphtheritic hemiplegia Babinski has drawn special attention, betrayed itself by an unusually vacant expression, which persisted after the facial palsy had disappeared, by torpor and apathy, and especially by amnesia. For some time after he had recovered his power of speech he would frequently forget his own name and address, the names of his nurses, and the letters of the alphabet. On one occasion fæces and urine were passed in bed. A vigorous moral tonic was exhibited and incontinence did not recur. Improvement gradually occurred, but it was not until a month after he was first allowed up that he showed any inclination to take an active part in the games of the other children. When he left the hospital on March 23rd, 1905, after a stay of 123 days, his condition was as follows:—He could walk and run fairly well, though with a very perceptible limp. The fingers of the right hand could be moved at will, but were not able to grasp any object. There was no wasting of muscles nor contractures. The cutaneous reflexes were active on both sides, having already returned to the normal on Feb. 14th, the ninety-first day of the disease. The knee- and ankle-jerks, which had been entirely absent till the ninetieth day of disease, were only present on the right side. His speech was unaffected, and there was no obvious mental deficiency. Since leaving the hospital there has been slight improvement, but complete recovery has not been attained.

Though several cases doubtless pass unrecorded, hemiplegia following diphtheria is so uncommon that Slawyk (1), writing in 1898, had been able to collect only 50 cases. A search through literature has enabled me to add 15, thus bringing up the total to 65, including the present one, and another that has occurred subsequently at the same hospital. The earliest of these 15 cases is that of Sir W. Gull (2). Right hemiplegia developed, and was attributed by Gull to cerebral thrombosis. The hemiplegia remained for several months, after which there was slow improvement. Humphry's (3) case, a boy of 11, developed right hemiplegia about the fourteenth day of disease, associated with paralysis of the palate, pharynx, and larynx. Death occurred from paralysis of the diaphragm. *Post-mortem:* a small area of suppuration with softening of the adjacent brain substance was found in the left cerebral hemisphere. Rosenthal's (4) case, a girl of 15, developed right hemiplegia in the third week after recovery from the initial angina. Paralysis of the palate and diplopia occurred at the same time. The skin on the affected side was insensible to electrical, thermal, and mechanical stimuli. In Hunter's (5) case, left hemiplegia came on in the third week, and was associated with cycloplegia, paralysis of the soft palate, muscles of the neck and back, and both legs. Sensation was normal. The superficial reflexes were diminished on the left side of the body, and both knee-jerks were entirely absent. Rigidity and slight atrophy of the left arm ensued. Recovery and some improvement occurred. The hemiplegia was regarded by Hunter as due to hæmorrhage into the right internal capsule. Wohlgemuth's (6) case was that of a girl, æt. 8. Right hemiplegia occurred at the thirty-second day. No cardiac disease was present, but much albuminuria. Recovery took place. Woollacott (7) says that in 4,000 consecutive cases of diphtheria at the Eastern Hospital, hemiplegia occurred only twice. Both cases recovered. It is interesting to note in this connection that the present case is the first of the two solitary instances of hemiplegia that have been met with among 4,407 consecutive cases of diphtheria that have been admitted to the Grove Hospital since it was opened in 1899. The other case was that of a girl, æt. 5. The initial faucial attack was very severe. Palatal paresis occurred on the tenth day. On the fifteenth the heart showed signs of dilatation. On the seventeenth, right hemiplegia occurred. On the eighteenth, death took place, ushered in by coma. Albuminuria was present on the seventh, and persisted till death. No autopsy was held, but cerebral embolism was probably the cause of the hemiplegia. In Mariottini's (8) case, a few days after the subsidence of the angina, endocarditis and left hemiplegia developed. *Post-mortem:* A focus of softening was found in the external capsule, corpus striatum, and internal capsule. The hemiplegia was caused in this case by an embolus due to endocarditis. In Breton's (9) case, the girl, æt. 3, had right hemiplegia and livid spots, followed by gangrene, on the left leg. The hemiplegia persisted for eight months, though the child could walk by dragging her leg. There was doubtless in this case endocarditis and multiple emboli. Teillais (10) recorded 3 cases in children æt. 6, 7, and 9 respectively, in which hemiplegia was associated with ocular and palatal palsies, and attributed the phenomena to cerebral hæmorrhage. Two recovered, one died. Knoepfelmacher (11) recorded a case of right hemiplegia, preceded by early affection of the palate, in a girl, æt. 4. Recovery took place, but the paralysis persisted. He regarded an encephalitis, with lesser probability an apoplexy, as responsible for the condition. Of the 65 cases, 20 were males, 30 females. In 15 the sex was not given. The ages of the patients ranged from 1½ to 15 years. Right hemiplegia occurred in 38, and left in 22. In 5 no details were given.

The occurrence of the hemiplegia took place at the following dates. In the first week no cases, in the second 9, in the third 20, in the fourth to sixth, 11. In 14 cases where no exact date is given it is said to have developed in convalescence, in 11 cases no time is given. Recovery took place in 33, death in 18; in 4 no details are given.

Autopsies were held in 15 cases.
Hæmorrhage was found in 1.
Thrombosis in 2.
Embolism in 10.
Embolism and thrombosis in 1.
Sclerotic atrophy of one hemisphere in 1.

In all the cases where details have been given the initial faucial attack was severe. Albuminuria and ordinary diphtheritic paralysis were present in a large number. Complete recovery was rare. Levi (12) instances only 4 such cases. Almost always contractures and atrophy have supervened in the paralysed limbs. Hemichorea, athetosis, and idiocy are mentioned by Slawyk as sequelæ. Sensibility in most cases was intact. In this respect Rosenthal's case, just quoted, was a remarkable exception. It must be remembered, however, that most of the cases occurred in young children, in whom an accurate éstimation of disturbance of sensibility is impracticable.

As Babinski (13) has clearly shown, hemiplegia differs from all the other palsies of diphtheria in being primarily a vascular lesion. Thrombosis, embolism, and hæmorrhagic encephalitis are the respective pathological states which give rise to the condition. The nervous system is not primarily attacked as in the common forms of diphtheritic paralysis, but secondarily affected by damage to its blood-supply in one of the three ways mentioned. Slawyk accentuated the fact that a clinical distinction between embolism, thrombosis, and hæmorrhage is impossible, so that in the present case the exact nature of the cerebral lesion cannot be determined. From the definite evidence of cardiac mischief, the probability is in favour of embolism being the cause, as in 10 out of 15 recorded cases in which an autopsy was held. Emboli in malignant diphtheria may be met with in other sites than the cerebral circulation. In Abercrombie's case (14), infarcts were found in the kidneys and spleen. A fatal case of pulmonary and femoral embolism was reported by Poupow (15). Marfan (16) recently narrated at the Société de Pédiatrie at Paris the history of a case of embolism of the abdominal aorta during convalescence from malignant diphtheria. Precocious palatal palsy, enlargement of the liver, and alteration of the normal cardiac sounds preceded the onset of symptoms as in the case under discussion.

Among other features of interest in this case are the early onset of palatal palsy and enlargement of the liver characteristic of the malignant forms of diphtheria (17), the association of characteristic diphtheritic palsies concurrent with the hemiplegia, the triviality of the serum manifestations in spite of the massive doses of antitoxin (18), and the alternate administration of belladonna and bromide of potassium in cardiac vomiting suggested to me first by Dr. Garratt (19).

I am indebted to Dr. J. E. Beggs, medical superintendent of the Grove Fever Hospital, for permission to publish this case.

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THE INSANE AND THE GENERAL PRACTITIONER.—I.

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MOST medical men have to deal professionally with insane persons from time to time, but as comparatively few persons become insane within the area of practice of any single individual, contact between the general practitioner and such patients is to be regarded rather as an incident in his medical work than as a part of his regular duties. For this reason, perhaps, the subject of insanity is assigned a comparatively insignificant *rôle* in the medical student's curriculum; and when he has assumed later the full garb of the qualified physician, it can hardly be said to receive quite the amount of attention at his hands that it deserves. And yet the great and serious responsibility associated with the action of medical men with respect to the insane more than counterbalances any seeming unimportance that the comparative infrequency with which such action is called into requisition might at first sight appear to indicate; and if even this one point be considered, that by a stroke of the pen any medical man can deprive a fellow-creature of his liberty, that most precious of all our possessions, and when the grave consequences that may follow such action on his part are taken into account, it becomes impossible to deny that the subject is one which demands the most anxious study and consideration.

That this is not an over-statement will be immediately apparent if we consider under what circumstances an insane person comes under the cognizance of the medical practitioner. A doctor may be called on at any moment to examine and certify as to the insanity of a patient, the result of which is that the latter has to be confined in an asylum, or segregated from his family and placed in private care. He may have to determine whether a testator is mentally competent at the time he makes his will—an act which may have a very serious bearing on the future of those affected by it. He may have to decide whether a man accused or convicted of crime, possibly of the capital offence of murder, was in such a condition as to render him legally unaccountable for his actions at the time the crime was committed. His decision in this case may mean life or death to the person implicated. He may be consulted about patients who present merely incipient signs of mental derangement, but who, if proper treatment be immediately employed, may escape their full development into confirmed insanity; and his advice may be sought as to the propriety of persons marrying in whom, or in whose families, there may be hereditary predisposition. On the action which a medical man may take under these varied circumstances hang issues always important, often momentous.

Criteria of Insanity.—Without going into any unnecessary details—for fuller information the practitioner must consult some of the excellent text-books now available on the subject—it will be advisable to touch briefly on the evidences of insanity, those considerations which enable us to determine in any given case whether insanity exists or not, the symptoms, in fact, on which we base our diagnosis. It is all the more necessary that the practitioner should be familiar with these, at any rate with the leading facts as regards the diagnosis of insanity, because he may at any time be called upon to justify his action with respect to an insane person before a law court, when, if he betray any ignorance or hesitation as to the grounds upon which such action was taken, he is certain to expose himself to, perhaps not altogether unmerited, censure or ridicule.

Psychology recognises three great departments of mind—intellect, emotion, and volition, which includes conduct. In more popular language—thought, feeling, and will with the actions which it initiates and controls. And in the examination of a patient it will be well to test his mental condition in these three spheres in order. Method always conduces to accuracy and dispatch. The normal mind exercises certain *intellectual* functions or faculties which may be enumerated in order as follows, from the simplest to the highest and most complex: Attention, sensation or perception, ideation or conception, comparison, judgment, reasoning, memory, and imagination. One or more, or all of these may be affected in insanity, and each should be separately tested. As regards the patient's *emotional system*, deviations from normal are shown in depression, exaltation, or perversion of feeling, any of which are, as a rule, perfectly obvious, particularly as there is seldom or never any attempt (on the part of the insane) to conceal them. In fact, a patient could hardly do so if he would. Our feelings more than anything else determine what we are; they are the mainsprings of our actions, the chief ingredient in our personality; we may almost say they *are* ourselves. Consequently, any change in them involves a change in personality, both subjectively as regards the individual and objectively as he appears to others. And so, in popular language, one of the commonest descriptions of an insane man is that he is "not himself"; his personality the *ego* that was, has somehow altered, and he is no longer the man he used to be. Perverted feeling as regards their own relatives is of very frequent occurrence in the insane, many of them coming to regard wife, child, or bosom friend with feelings of suspicion, hostility, or even hatred. Lastly, a man's *will* may become perverted, which will be shown in his acts and conduct. There may be an absence of will, an inability to initiate or carry out any definite line of action, a reduction to a condition of impotence, an incapacity to make up one's mind. In this condition a man will deliberate for an unconscionable time which boot he will put on first ("insanity of doubt"), and in the end, perhaps, give up the problem in despair. Or there may be an insubordinate condition of will in which it submits to no control, and is unamenable to the ordinary restraints of civilised society, when a man's conduct may become extravagant, unruly or violent. This sphere of action or conduct is more important from a medico-legal standpoint than either of the others. A man may conceal his thoughts or his feelings, even when they are perverted, but he cannot hide his conduct; that is known and read of all men. As long as mental derangement is confined to the departments of intellect and feeling the law looks on it with indifference; it is only when it becomes translated into action that it sees any grounds for interference.

The foregoing paragraphs deal with the symptomatology of insanity in a more or less general way. It may not be out of place to dwell a little more particularly on two or three symptoms of a more concrete and specific character. As absolute proof of insanity the existence of *delusion* has been given—and perhaps rightly given—by the law the premier place. Many definitions of what delusion is have been attempted both by lawyers and medical men. Spitzka, in his work on "Insanity," gives one of the best, which he states is a legal definition somewhat modified: "A delusion is a faulty belief out of which the subject cannot be reasoned by adequate methods for the time being." On the legal side, Sir John Nicholl, as far back as 1831, defined a delusion as "the fancying things to exist which have no existence, and which fancy no proof or reasoning will remove." These two definitions are practically the same, and the latter clause of each is of great importance. Any person may have "fancies" or "faulty beliefs," but a sane person is ready to abandon them on reasonable proof being given him that there is no foundation for them. The insane man, on the other hand, refuses to give up his erroneous notions, no matter how absurd they are, and no matter what amount of proof is forthcoming of their absurdity; on the contrary, he clings to them with all the greater tenacity. In short, a sane man can correct his delusion, an insane cannot.

Hallucinations and Illusions.—There has been in past times, and even now there is still in some quarters, a certain amount of confusion in the use of these terms; they have been used as if interchangeable, and the French have no word "delusion," but use the word "*illusion*" for what we call delusion. But it is better to accept the specific meaning which is attached to each of these terms by probably the vast majority of both legal and medical authorities, according to which an "hallucination" is "a false perception of the senses without an external stimulus," or "a sensation referred by the patient to an external object *which has no existence.*" An "illusion" is "a false perception of the senses with an external stimulus," or "a sensation arising from an external object but *misinterpreted* by the patient." If a man sees a black cat on the floor and imagines it to be an imp of darkness, he is the subject of an illusion; if there is nothing on the floor and yet he sees the spectral demon, that is an hallucination. One of the commonest hallucinations in an insane patient is the hearing of voices where there are no vocal sounds to give rise to the sensation. Where there is some sound which he misinterprets, as when he takes the tinkling of a bell to be an angel's message, he is suffering from an illusion. When testing a patient's mental condition it is well to bear these differences in mind.

Insane conduct is shown in various ways, such as mischievousness, destructiveness, indecency, fantastic modes of dress, uncleanly habits, extravagant gestures, loud talking, refusal of food, violence, suicidal attempts, &c.

On reverting to the different functions of mind, as previously enumerated, it will be seen that any of these overt signs of insanity is referable to one or other of these. Thus, an hallucination is due to disordered *sensation;* an illusion to a false *perception;* a delusion to an error of *judgment;* and the manifestations of insane conduct are due to perversion of *will.* In examining an insane patient his facial expression, gait, conversation, and gestures, and his general demeanour should always be noted, as these very frequently betray the abnormal condition. The handwriting and the style and subject-matter of a patient's letters will often be found to be of great significance, even in cases where conversation and conduct appear quite rational. Delusions are often discovered in this way.

The existence of *heredity* on the side of either parent should always be inquired into, as it is a most important consideration when associated with symptoms of insanity, and in doubtful cases it may even be the determining factor in the formation of a diagnosis.

Presuming the practitioner to be in possession of the facts above enumerated, it remains to consider the occasions on which he may be called on to put them into practical use. And, first, as regards the—

Certification of the Insane.—Not the pleasantest part of a medical practitioner's duties is the certification of insane patients. In certain cases where there is a tendency to violence it is a duty not altogether free from danger; and there is always the risk, should the patient eventually recover and be discharged from an asylum, of his retaining a feeling of enmity, even a life-long enmity, against the doctor as one of the principal agents in depriving him of his liberty, and subjecting him to the stigma of having been confined in an asylum. This latter risk is more to be feared in the case of the well-to-do than in that of the humbler classes. For the insane poor, at least until private care for them is sanctioned by Act of Parliament in this country as in Scotland, there is practically no alternative but the asylum, and the large majority of such patients seem to realise this, and on discharge, with but few exceptions, do not harbour any resentment against those who sent them there. But with the well-to-do the case is different. Here there is the option of sending to an asylum or placing under private care. And while in the large majority of cases the latter course does not arouse vindictive feeling on the part of the patient, confinement in an asylum, in some cases—where the mind is comparatively clear—from the very first, in others later on when the initial clouding of the intellect has passed away, the realisation of his position excites his keenest indignation; and on his recovery this indignation is liable to be visited on all who were instrumental in compassing, as he thinks, his disgrace. The mutual love and affection which formerly existed between himself and his family is replaced by a feeling of bitterness and animosity, which even time fails to soften or remove. In one case known to the writer a father disinherited his eldest son solely because he had found it necessary to place him for a short time in an asylum. The action was never forgiven (*a*). The certifying of an insane person, therefore, an act which constitutes him then and there an "official" lunatic, is one which demands the most careful consideration, and should never be lightly undertaken by the medical attendant. This is not to be taken as implying that a patient should not be placed under proper treatment as soon as possible after the first symptoms of derangement reveal themselves. Quite the contrary. The earlier such treatment is employed the better for the patient. And it is a matter of experience that such patients almost invariably do better when removed from their own homes to new surroundings, not necessarily to an asylum. No doubt, if recovery had alone to be considered, removal for those who can afford it to a good-class private asylum would in most cases be attended with the best and speediest results. But as long as detention in an asylum carries with it in the eyes of the public a certain stigma and reproach, which often tells against a man in after life, so long will there be some hesitation on the part of relatives and doctor to take this course if it can be possibly avoided. Hence if a patient is not dangerous to himself or others, and is fairly amenable to moral suasion, the alternative course may be adopted of placing him in charge of a medical man in whose house he will be treated as far as possible as one of the family, and where he can enjoy the comforts of sweet domesticity, an ingredient of no small value in the remedial treatment of the insane. If this is not feasible, or possibly too expensive, the

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(*a*) The sequel to this incident may be of some interest. The old man died and was buried. After the funeral the will was read out, as usual, in the presence of the relatives. The first will had not been destroyed, but had been revoked, and the property by the second will was left to the younger son, who at the reading of the will was standing with his back to the fire. He saw the downcast look on his elder brother's face, asked to see the will, scanned its contents for a moment, and with the words, "It's all right, W——, old fellow, the old will stands," dropped his father's last will and testament into the flames behind him. Such nobility of character had its reward, for this gentleman, a man of brilliant talents, subsequently attained to a high position in the Government of India.

patient might be placed with some non-medical family who have had some experience in the management of the insane, and arrangements should be made for him to have the benefit of regular medical attendance and supervision. Where patients are violent or suicidal, of course, an asylum is the only place to have them located.

In the case of the poorer classes, those whose circumstances do not admit of their being treated in a private asylum, and whose home surroundings in the majority of instances are not such as to conduce to their recovery, removal to their district asylum as soon as possible after mental derangement becomes obvious is the wisest course. By far the greater number of recoveries in these institutions are in those cases which have come early under treatment; and this is a fact which the dispensary doctor, who has most to do with such patients, would do well to impress on their relatives, as many of them, through mistaken views regarding insanity and the object of asylum treatment, are allowed to drift into a condition of helpless chronicity by being kept at home for months, and even years, before any systematic treatment is employed for their malady, which thus becomes more and more confirmed.

There are two modes of admission of pauper patients into asylums—(1) by the house form; (2) by magistrate's warrant. In the case of the former, a "declaration" of the patient's insanity has to be made before a magistrate by a relative or other interested person; a medical certificate is filled and signed by a doctor; and the magistrate, having read this, recommends the patient to be detained in the asylum. This is a legal authority for the medical superintendent to admit him into the asylum. In the case of the warrant a sworn information must be made that the patient has committed or was about to commit an indictable offence, a warrant is issued, and the patient is arrested by the police and brought before two magistrates, who call in the nearest dispensary medical officer to examine into the patient's mental condition, and on his certifying that he is insane the magistrates order him to be committed to the asylum. Such a method as this for dealing with an insane patient is an anomaly in the present stage of our knowledge and civilisation, and Ireland is the only country in the world where such a procedure exists, or would be tolerated. Insanity is the outcome of disease, and to have a man arrested as a criminal whose acts, even if they are violations of the law, are the result of his insanity, and acts for which he cannot justly be held responsible, is a proceeding as cruel as it is illogical. And the persistence of such a procedure in this country is not altogether creditable to the legal authorities who are concerned with the interests of the insane. It should have been abolished long ago. Notwithstanding the plain objections to this method of dealing with the insane it is one which enjoys a certain amount of popularity both with the public and with the doctors. With the public (of the class affected by it), because it saves relatives all expense in getting the patient into the asylum; they simply "press the button," the police do the rest; with medical men, because a fee is allowed for certification in warrant cases, whereas none is given in the case of the House Form. These are also anomalies which should be removed. Provision should be made for the removal of all insane patients who are entitled to Poor-law relief to the asylum without expense to their relatives which they are ill able to afford; and there should be a legal fee for the certification of all cases of the insane poor, whether they are sent to the asylum on the House Form, or on warrant. According to the last report of the Inspectors not one-third of the total admissions to asylums were on the House Form, some 1,150 in all. Were a fee of one guinea allowed in each case this would mean an average additional expense to each county of about fifty guineas annually, a mere bagatelle as compared with the entire Poor-law expenditure.

In the filling up of certificates, one or two suggestions may not be out of place. Under the heading "Prominent Symptoms," "Delusions," or "Delusions and Hallucinations," is often entered. This gives very little information, and not at all infrequently no hallucinations are found to exist although stated to be present. It would be far more to the point, and would materially enhance the value of the information, if in every case where a delusion or hallucination exists the certifying doctor would specify briefly the nature of it. Again, the "Probable Cause" is sometimes given as "brain-disease," a useless piece of information except in any case, and these are of rarest occurrence, where examination has revealed distinct symptoms of organic disease of the brain, hæmorrhage, tumour, &c. No doubt, all insanity is due to brain-disease in the sense that it is caused by functional or organic disease of that organ; but it is this which makes such a statement valueless. What is really wanted is the antecedent conditions to which the attack of insanity may probably be attributed. In other words, its *etiology*, not its *pathology*, is sought to be ascertained.

While on this subject, it may be worth while to quote a passage from "The Insane and the Law," which is both practical and amusing:—

"There is no part of the certificate on which medical men (especially country ones) are more loose and apt to fall into ludicrous errors than the portion which distinguishes 'Facts indicating insanity observed by myself' from 'Facts communicated by others.' Thus in practice a certificate has been known to be filled up under the head of 'Facts indicative of insanity observed by myself' with the remark, 'Reads the Bible constantly,' as if a frequent reading of that book were of itself a necessary indication of insanity; or with the information, 'His mother tells me he is very restless at nights.' The facts thus vouched for neither purporting to be observed by the certifying practitioner himself nor a necessary indication of insanity.

"Moreover, the facts observed ought to be stated in some detail, and followed by some definite well-considered statement that they are untrue. A good example of the care needful in both these respects was afforded by a medical man who, having a patient suffering from the delusion that his feet were 100 yards long, filled up the certificate simply, 'Fancies that he has large feet." This certificate was, of course, sent back, accompanied by suggestions to the effect above pointed out, and intimating that the least that could be accepted was some statement to the effect 'the same being untrue.' The practitioner in question chanced on the next occasion to have to certify a patient who was violently maniacal, and during his ravings used the foulest language, and being himself lost to any sense of humour, and desiring to take the hint previously conveyed to him, he certified these facts, and as an example added, 'Called me an infernal old fool, *the same being untrue*'!"

The possession of property gives an additional importance to the certification of private cases. Here the law requires an examination to be made independently by two medical men. The issues involved are far greater than in the case of the pauper patient. A medical man, therefore, can hardly be too cautious in dealing with such cases, as any error on his part may have the effect of landing him in a law court. He should invariably take full notes of the case, and especially of facts which come under his own observation, and at the time when the examination is made. Memory is treacherous, and no doubt many a man has had good reason to regret that he trusted to it when he finds himself under the fierce fire of cross-examination by counsel. It would seem hardly necessary to urge that no doctor should sign a certificate of insanity without having personally seen and examined the patient. And yet in a case which came into the law courts comparatively recently, this mistake was made, one medical man having certified that a patient was insane merely on information supplied to him, and without having verified this by his own observation, The law is perfectly clear, however, on this point; the certifier must state that he personally examined the patient separately from any other medical practitioner. This is supposed (by the legal mind) to be for the safety of the patient, but it is a question whether the object would not be better attained by allowing a consultation between the two medical men who examine the patient just as in the case of any other form of disease. Faulty observation on the part of either would be more readily detected, and any doubtful point cleared up by re-examination. The idea underlying such a provision as this would seem to be an unworthy suspicion of the integrity of medical men. The object of the rule can hardly be anything else than to provide against collusion. But if collusion were desired it could just as easily be effected under the present regulations as if it were permissible that the doctors should make a joint instead of a separate examination.

(*To be continued.*)

Clinical Records.

ROYAL BRISTOL HOSPITAL FOR WOMEN AND CHILDREN.

Case of Intestinal Obstruction from Strangulation by persistent Meckel's Diverticulum.

By JOHN EWENS, L.R.C.P. Lond., L.R.C.S. Ed.,
Consulting Surgeon to the Hospital.

The recent editorial in the columns of this journal recalls to my memory an interesting case that came under my care some few years since.

Alice M. K., æt. 2 years 3 months, admitted to the hospital under my care on September 7th, 1889, suffering from obstruction of the bowels, in a collapsed condition.

History.—The child was quite well on the morning of September 1st. In the afternoon, between four and five o'clock, she complained of pain in the abdomen, and vomiting commenced at six o'clock and persisted through the night. The next morning she appeared a little better, the pain was not so severe and the vomiting had ceased, but in the evening returned, and has continued ever since. On the 5th, five days from the commencement of the symptoms, it became stercoraceous. The bowels had acted on the morning of the 1st September, before the pain began, but have not been opened since, though various purgatives have been administered and injections given by the medical man in attendance. No flatus has been passed. Blood only passed once after the injection, and then a clot came away. No food has been taken since the symptoms began. Before the symptoms commenced she had eaten some plums, but she was very careful not to swallow the stones.

On admission at 1.30 p.m., the collapse was extreme. The abdomen was greatly distended, but no definite hardness could be felt anywhere, and examination per rectum yielded no result.

An injection was carefully administered through a long tube without result.

It was then obvious that an operation was necessary, and it was decided to give the child the only chance of relief, though a very feeble one, on account of the extremely prostrate and exhausted condition to which it was reduced.

Operation.—At 3.30 p.m. the abdomen was opened in the usual method by an incision reaching from about 1 inch below the umbilicus nearly to the pubes. On passing the fingers into the peritoneal cavity some adhesions were distinctly felt to yield, but nothing like a twist, incarceration, or intussusception could be detected. As the exhausted condition of the child precluded a more prolonged examination, and as the exact seat of the obstruction had not been definitely made out (although doubtless as proved by the P.M. examination the cause was removed by the breaking down of adhesions) it was thought best to make an artificial anus, which was done in the ileum, shown at the P.M. examination to have been about 5 feet above the ileo-cæcal valve. This was proved afterwards to have been an unnecessary proceeding, as doubtless, had the child lived long enough, the action of the bowels would have been restored. But under the circumstances above named a fuller examination was considered dangerous. The child died at 8.30 p.m.

Post-mortem, September 8th.—There was a persistent Meckel's diverticulum passing from the ileum 2 feet above the valve, to the umbilicus, where it ended in an expanded cul-de-sac. The length of the diverticulum with the cul-de-sac was 4 inches. The cul-de-sac leaked from innumerable minute holes, when a current of water was passed through the bowel. It (the cul-de-sac) was covered on one side with recent lymph, and to this probably had been adherent a coil of intestine, on the mesentery of which was a corresponding patch of recent lymph. This recent adhesion had probably been broken down during the examination of the abdomen at the time of the operation, and thus the portion of gut which was strangulated in the arcade formed by the bowel being adherent to the diverticulum was liberated. This portion of bowel, which had been strangulated was about 18 inches above the part where Meckel's diverticulum came off, and was differentiated from the rest by a well-marked boundary between the full and empty gut. The intestines were, of course, not greatly distended, because of the artificial anus made during life. There was no general peritonitis, nor was the bowel above the point where it had been constricted very congested.

Remarks.—This case presents many points of interest, some of which have been incidentally alluded to in the report, and my attention has been recalled to it by the very interesting article on page 493 of this journal, which points out the very considerable frequency of obstruction from a persistent diverticulum. The case was reported at a meeting of the Bristol Medico-Chirurgical Society in the year 1890, and it was then considered unique, or at least very rare. The great mortality noted by Dr. Miles Porter brings this cause of obstruction into very great prominence, and hence the question whether in all cases of laparotomy for obstruction it would be desirable to examine first the region of the umbilicus, to see whether the diverticulum is persistent, and if so to follow it up to its insertion into the ileum, thus setting free any loop of intestine entangled in it, and avoiding the tearing which doubtless occurred in my case. It could then be removed by ligaturing both ends.

Mansel Moullin says: "In one or two cases it has exerted such traction on the intestine as to close its lumen completely, and finally to allow the intestine to become extruded through it, the mucous membrane prolapsed first, followed by more and more of the bowel, until there is a huge intensely congested protrusion, turned inside out, and projecting through the umbilicus. In one case I was obliged to open the abdomen before the mass could be reduced."

Bowlby, *Surgical Pathology*, p. 569, says: "The diverticulum varies in length from one to twelve inches." In the latter case, it must be a fearful source of danger.

Treves, quoted by Moullin, considers that one-fourth of the total number of cases of intestinal obstruction from all causes are due to strangulation by bands or through apertures, and of this fourth rather more than one-fifth are due to the presence of Meckel's diverticulum; this would produce a proportion of 5 per cent. But the more recent experience of Dr. Porter puts this calculation completely in the shade, and renders more careful examination in cases of laparotomy absolutely necessary.

Agnew and other surgical authorities refer to this as an important factor in the production of intestinal obstruction.

The following may be considered interesting as indirectly connected with the surgery of this region.

In the year 1886 I met with a case of sarcoma originating in the urachus, which I exhibited at the Bristol Medico-Chirurgical Society, and is referred to by the late Mr. Grey Smith in the third edition of "Abdominal Surgery." The child, æt. 2½ years, was admitted under my care into the children's department of the hospital. It is illustrative of the abnormal conditions which may exist in connection with this embryonic body, which may be regarded as a site likely to favour the deposit of sarcoma. Mr. Erichsen says: "The anatomical type of sarcoma is found in embryonic tissue." I endeavoured to remove it, but found its attachments too firm to justify proceeding with the operation. It was at that time about the size of a large orange. The abdominal incision healed readily, and the child lived about six weeks, and after death the tumour weighed 10 lbs.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

Meeting held December 8th, 1905.

The President, Mr. Clutton, in the Chair.

Mr. J. Jackson Clarke read a paper on—

THE PRESENT POSITION OF THE TREATMENT OF CONGENITAL DISLOCATION OF THE HIP-JOINT,

illustrating the subject by giving the results obtained by him in two series, each of ten consecutive cases treated by Lorenz's manipulative method. In the first series of cases the ages of the patients varied from three to nine years, and two of them were cases of bilateral dislocation; there were thus twelve joints. Of these, nine (75 per cent.) were cured. In three the head of the femur was "anteverted" (as it had been termed) at the operation. Of these cases of anteversion one had relapsed, another was doubtful, and the third was firmly established, the head of the femur being placed beneath the anterior superior iliac spine, and the new joint having a full physiological range of movement; the last-named patient was a girl, æt. 8, who had a bilateral dislocation, and she now walked as firmly with the "anteverted" as with the other joint which was completely cured. In the second series of ten cases (the ages of the patients being from 2 to 9 years) there were three bilateral dislocations. Complete anatomical reduction had been effected in every one of the thirteen joints (100 per cent.). In neither series of cases was there any kind of operative mishap. In October, 1904, when Mr. Clarke had shown before the Society one of the patients of Series 1, in an early post-operative stage, some scepticism had been evinced, but all doubt about the efficacy of the treatment was now completely removed. Mr. Clarke expressed the belief that irreducible cases would soon cease to exist, and pointed out that his second series of cases went far to prove the correctness of this view. The paper was illustrated by lantern slides.

Mr. J. R. Lunn asked what was the sex and age incidence in Mr. Clarke's cases?

Mr. Clarke, in reply, said that the proportion of females to males was nine to one. The best age for the operation was about three or four years; after five it became increasingly difficult.

Dr. E. W. Goodall communicated a case of

TYPHOID FEVER WITH PERITONITIS,

not due to perforation, in which laparotomy was performed. The patient was a boy, æt. 10, who was admitted to hospital on August 21st, 1905, with typhoid fever, on the ninth day of the disease. He had a mild attack, with very slight abdominal symptoms, till August 31st, when in the morning he complained of abdominal pain; in the afternoon the pain was worse, the abdomen was rigid and moderately distended, the pulse-rate became more frequent than it had been, and the temperature rose to 104° F. From these signs it appeared to Dr. Goodall probable that perforation had taken place; accordingly, laparotomy was performed. No perforation, however, could be found after a careful and prolonged search, but there was very acute peritonitis in the neighbourhood of the ileo-cæcal valve. The inflammation was most intense in the bowel close to the mesentery and in the mesentery, of which the glands were considerably enlarged. The lymph and serum were quite healthy. The abdomen was closed and the patient made an excellent recovery. The case was recorded:—(1) As an instance of the difficulty in the diagnosis of perforation; (2) as an example of what, in Dr. Goodall's experience, was an unusual form of peritonitis in typhoid fever. If peritonitis were not due to perforation of the bowel or of some other viscus, it was usually most intense opposite the intestinal ulcers, indicating direct spread of inflammation, but that had not been so in this case; (3) the case also illustrated the slightness of the symptoms that might accompany peritonitis—at any rate, its early stages.

Mr. W. G. Spencer read a paper on

SEPTIC PERITONITIS

occurring early in the course of typhoid fever without perforation. He related the case of a boy, æt. 12, who was seized with acute pain in the abdomen followed by vomiting and abdominal distension. Signs of acute septic peritonitis were present on the third day, with impaired resonance and resistance in the right ileo-cæcal fossa. The only feature in which this case differed from appendicitis was that the motions were pale, pasty, and odourless. There was no rash. At the operation peritonitis was found, with reddish turbid fluid in the pelvis. The ileum and cæcum, along with the appendix, were congested on the surface, but not otherwise altered. The resistance previously observed had been due to enlarged mesenteric glands. After the operation the peritoneal symptoms subsided, but the patient passed through a severe attack of typhoid fever, during which he was seen by Mr. W. B. Cheadle. Widal's reaction was obtained four days after the operation. The temperature became normal after five weeks. The wound healed without hernia. Four fatal cases of this kind had been recorded during the present year. In all the appendix was not diseased; there was no sign of perforation, and the ulcers had not extended to the peritoneal coat. Discussing the nature of these cases, Mr. Spencer expressed the view that they were due to an especially virulent infection spreading through the intestinal wall at an early stage of the typhoid fever. It is necessary to operate at once for the septic peritonitis without waiting to confirm the diagnosis of the typhoid fever.

The President commented on the difficulty of diagnosis between appendicitis and typhoid fever. The operation seemed to do good even when no perforation was present.

Dr. F. H. Hawkins referred to a fatal case of perforation in typhoid in which no perforation was found. In another similar case operation was performed, and the patient recovered.

Dr. T. Porter Parkinson asked whether the occurrence of leucocytosis might be regarded as some use in diagnosis?

Mr. A. E. J. Barker thought that operation for peritonitis in typhoid was often looked upon too seriously.

Dr. Goodall, in reply, said that thirty-nine out of fifty-four fatal cases of peritonitis in typhoid were due to perforation. In the cases without perforation the ulceration was very deep, and suggested extension as the cause of the peritonitis. In his opinion the diagnosis of peritonitis warranted immediate operation.

Mr. Spencer said that there were three stages of typhoid fever in which peritonitis occurred; there was the very early stage, as in his case; there was the middle stage, in which the ulcer might be very deep and the peritonitis due to extension; and lastly, there was the later stage when the peritonitis was due to perforation.

Mr. T. K. Kellock communicated a case of

TRAUMATIC PANCREATIC PSEUDO-CYST.

The patient was a man, æt. 20, who was kicked by a horse over the upper part of the abdomen on the day of his admission to the Middlesex Hospital under Mr. Henry Morris. For three weeks he was troubled by a continuance of the pain and occasional vomiting after food, the temperature was irregular, and the pulse was rather feeble. Evidence of fluid in the left pleural cavity was found, but an exploratory puncture only drew off one and a quarter ounces of turbid sterile fluid. A few days afterwards the patient became worse, and the upper part of the left side of the abdomen was found to be full and rigid, but resonant on percussion; the heart's apex beat was displaced upwards to the third interspace. Under an anæsthetic an incision was made over the ninth rib in the left anterior axillary line and about one and a half inches of bone were removed. The diaphragm was adherent, and on making an incision through this, a large cavity was found from which clear fluid escaped at considerable pressure. The quantity of fluid that was collected was eighty-eight ounces, and on examination proved to contain pancreatic secretion. A drainage-tube was inserted and the operation was followed by great relief to the embarrassed respiration. On several occasions a fresh collection took place and brought on a return of the symptoms. The most satisfactory form of drainage proved to be a gum-elastic catheter through which the average quantity of fluid that was collected was just twenty-eight ounces per diem. The amount of fluid escaping gradually diminished and five weeks after the operation the drainage was discontinued, and the escape of fluid ceased abruptly. No abnormality was detected in the stools. The patient was discharged after about three and a half months' stay in the hospital, the wound being then healed. He was seen six months after his discharge; he was then in good health, and was at work. Mr. Kellock referred to similar cases on record. In four of the eight cases reported the cystic formation had been consequent on a kick from a horse. He also commented in connection with his own case on the position in which the incision was made, the large quantity of fluid evacuated, and the sudden and unexplained recovery of the resulting fistulous opening.

Mr. W. Low had seen a similar case in a boy, æt. 6, who had been run over. A tense elastic swelling was found in the right hypochondriac region. At the operation this was found to be a cyst containing clear fluid that had started in the pancreatic substance.

The President referred to a similar case in which the pancreas had been bruised and fat necrosis had occurred. This change was similar in kind, but different in degree to the case just referred to.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Surgery.

Meeting held Friday, December 1st, 1905.

Mr. T. E. Gordon in the Chair.

TUBERCULOUS DISEASE OF THE SEMINAL TRACT.

Mr. Gunn read a paper on the surgical treatment of tuberculous disease of the seminal tract. Referring to those cases in which both testes are affected, and where the vesicles or prostate are also diseased, he showed that the course of the disease was not, as a rule, checked by the removal of the testicles, but sooner or later the bladder was infected, and from it the kidneys, and this ended in the death of the patient. Mr. Gunn advocated the complete removal of the disease, and told of two cases in which he had removed both testicles, both cords, both seminal vesicles and the prostate through inguinal and perineal incisions. In both cases the patient was up on the eighth day, with complete control over his bladder. In neither case has there been any sign of the disease recurring. The bladder was in each case carefully examined with a cystoscope before the operation, in order to be certain that there was not tubercular infection there.

Mr. Edward Taylor believed that the usual treatment of tuberculous disease of the testes by operation was very imperfect, a much more extensive procedure being generally requisite. It was almost certain that by the time the disease was fully manifest in the epididymis more distant parts of the seminal tract were also implicated, although the fact might be difficult to prove by the ordinary methods of examination.

Mr. Haughton stated he had performed two radical operations on such cases, but found he could not get good access to the seminal vesicles by the abdominal route. He wished to know from Mr. Gunn if he had experienced much difficulty in removing the entire seminal tract.

Mr. C. A. Ball alluded to the fact that cases were occasionally observed in which tuberculous disease of the seminal tract seemed to stand still for a considerable time. He had known of one case in which the disease had involved the deep urethra, and had ultimately healed up, leaving a stricture.

Mr. Gunn, in replying, dealt in more complete detail with the steps of the operation for removal of the seminal tract. He first exposed the vas by means of an inguinal incision, and traced it into the pelvis up to the point at which it was crossed by the ureter. The second stage of the operation consisted in exposing the prostate, as in perineal prostatectomy, and working backwards towards the seminal vesicle and terminal portion of the vas. If the latter was diseased its complete removal should be attempted, but if it appeared healthy, the perineal stage of the operation could be deferred to a later date.

Mr. W. S. Haughton and Dr. Rowlette contributed a paper on

STERILISATION OF THE HANDS.

Mr. W. S. Haughton after referring to some investigations he had carried out on the subject during the past few years, stated that his experiments supported the general view that "soap-hot-water-alcohol" method was the best, but that during the past twelve months he had experimented with "soap-hot-water-sublimate" method, tested on three different pairs of hands—the surgeon's, assistant's, and nurse's. The method was:—(1) Scrubbing for twenty minutes with soap, hot water and boiled nail brush, followed by (2) immersion for one to two minutes in sublimate, aqueous solution (1-500), which was rinsed off in normal saline before hands were put into (3) rubber gloves boiled for ten minutes. The skin of hands, nails and gloves were tested at the different stages of preparation, before, during and at end of operation. Some eighty square inches were searched thoroughly by sterile swabs on each pair of hands, and the nails (all ten) probed deeply with stout platinum wire before inoculation of tubes. This test, it was claimed, was more stringent than any hitherto put forward, and the results of culture proved that absolute sterilisation of skin by this method was difficult or impossible, and when obtained was not permanent—the recess under nails being the most difficult to disinfect. The rubber gloves, tested at end of operation, only once gave a positive result—*i.e.*, produced a culture. Some 200 tubes were examined. Air infection of gloves during operation was met by frequent washing in sublimate (1-500) which was at once rinsed off in normal saline to prevent entry of any chemical poison into the wound. These results indicate that rubber gloves are advisable. The clinical results in the year's work of cases operated on by this technique were highly satisfactory, and showed a continuous series of aseptic healing of wounds.

Mr. R. A. Stoney also mentioned the results of two series of experiments which were undertaken mainly for the purpose of proving the possibility of completely sterilising the hands, or, at least, of rendering them free from pathogenic organisms. In the first series, tubes of broth and agar were inoculated with snips of skin, portions of silk on which knots had been tied, and scraps from the skin of the hands and from under the nails. The method of sterilisation adopted was—(1) nail-brush and hot water and soap, 5 minutes; (2) alcohol, 2 minutes; (3) 0.2 per cent. biniodide of mercury, 2 minutes. In this series the results were not satisfactory, as although complete sterility was sometimes attained, staphylococci grew on the media on several occasions. In the second series, after washing in soap and hot water, the hands were steeped for 2 minutes in a mixture containing 60 per cent. alcohol, 6 per cent. strong HCl. and 1 in 1200 corrosive sublimate. Cultures were taken before and after operation. In no case did any growth of cocci occur, but on four occasions out of one hundred and twenty a growth of a sporing bacillus was obtained. As this was a non-pathogenic microbe the results might be considered perfect from a practical point of view. The conclusions drawn were:—(1) That it is possible to sterilise not only the surface of the hands, but also the deeper layers, and therefore the wearing of gloves is not a necessity; (2) the practical demonstration of anatomy and surgery on the dead body does not increase the difficulty of sterilising the hands; (3) owing to the variation in the tolerance of the skin of different people to the action of antiseptics, it may be impossible to sterilise the hands, and then the wearing of gloves while operating becomes obligatory. As a corollary of this it follows that everyone should experiment for themselves in order to find a suitable and reliable method of preparing their own hands for operation.

Dr. T. G. **Moorhead** gave details of the bacteriological aspect of Mr. Stoney's investigations. On several occasions he found *débris* on the surface of the agar or in the broth, so that the test was stringent. As regarded incubation, all tubes were kept until the eighth day, and some for a fortnight. When a growth was obtained it was plated out and the colonies examined.

Mr. T. E. **Gordon** and Mr. E. H. **Taylor** discussed the communications, and were in agreement as to the advisability of wearing rubber gloves in operative work.

HARVEIAN SOCIETY OF LONDON.

Meeting held December 7th, 1905.

The President, Mr. C. B. Lockwood, in the Chair.

Dr. **Seymour Tuke** opened a discussion on

THE ATTITUDE OF THE MEDICAL PROFESSION TOWARDS INSANITY.

Reference was made to the older methods of treating the insane; and a historical retrospect of the care of lunatics was given. The general impression is that morbidity and insanity are on the increase; but in the absence of general registration, reliable statistics are impossible. The legal and the medical attitude towards insanity were contrasted. Objections to the unsatisfactory Lunacy Act of 1890, and especially to the magisterial clauses were mentioned, and Dr. Seymour Tuke showed the advantages of the Scotch procedure in dealing with lunatics. Among important causes of insanity were given high pressure, love of luxury, excess, ease and enjoyment, and drink, poverty and misery at the extremes of the social scale. As regards treatment, emphasis was laid on the drawbacks and evil results of much that goes by the name of single care of patients. So far as the future is concerned, in reform the medical profession must have the last word.

Dr. F. **Claye Shaw** referred to the unsatisfactory attitude of the legal mind towards insanity, and the absurdity of the trial for murder of insane persons before an examination of the mental condition. The popular feeling that insanity is a stigma has to be reckoned with. Among causal factors, stress and social conditions were most important. Failing the help of the law and the church, the medical profession should raise their voice against the corruption of the streets, the shops, and some forms of literature. Laziness was also a vice which caused disease of the mind, which should be combated. Might not the treatment of insanity in the home and the asylum be improved. With the increase of knowledge, he was hopeful as regards the therapeutics of mind in the future, and thought assistance would be forthcoming from psychical researches.

Dr. R. **Percy Smith** referred to the difficulties in the way of the physician who might be desirous of removing patients from single care; difficulties on the part of the friends, difficulties introduced by the Lunacy Act of 1890 (the magistrate's certificate, the wording of the medical certificates, etc.). He contrasted unfavourably the position in England with that in Scotland. As regards the registration of lunatics, one had to reckon with public objections. Every one must agree that only people with knowledge and experience should be entrusted with the single care of insane patients. In the case of the poorer classes, certain borderland cases could be treated with advantage in general wards.

Mr. **Campbell Williams** inquired on the proportion of cases of insanity due directly or indirectly to syphilis.

Dr. E. **Payne** inquired whether the present tendency of sending quite young children to school did not interfere with healthy mental development and predispose to insanity later on.

Dr. T. **Hyslop** referred to modern squeamishness in treatment, and thought some of the older methods might be retained with advantage. He ridiculed the affected euphemism of referring to a mental breakdown as disorder of the "nerves." The duty of the magistrate under the Lunacy Act of 1890 was most unsatisfactory. Reliable statistics of insanity could only be obtained by registration, which might with advantage be extended to the unemployables. In dealing with the causes of insanity, he referred to the powerful interests of the drink traffic, with their corresponding influence on the affairs of the country, and to the increasing amount of irresponsibility noticed in people (parents and others).

Dr. H. C. **Phillips** and the **President** also spoke, and Dr. **Seymour Tuke** replied.

CENTRAL BOARD OF MIDWIVES.

Meeting held December 14th, 1905.

The President, Dr. Champneys, in the Chair.

The **Secretary** read a letter from the University of Manchester, urging the desirability of steps being taken to secure some degree of uniformity in teaching pupil midwives; (2) an equal number of examinations in London and in the provinces; (3) rejected candidates to be referred for, perhaps, three months before appearing again; (4) an additional fee for examiner presiding at a written examination; (5) some form of exchange of examiners between the centres so as to promote uniformity to standard required.

As neither Sir John Sinclair nor Mr. Ward Cousins was present, and further elucidation of the various points was needed, the matter was again held over for consideration.

Miss **Wilson** then moved that a resolution passed at the last meeting, deciding that pupils of the Cheltenham Nursing Institution to be ineligible at the next examination on account of delay in notifying, be rescinded. The ten days' delay had been made on account of some misapprehension about dates.

Dr. **Parker Young** seconded the motion. It was within their sphere to alter, and an act of injustice would be done if no such alteration were made.

The **President** admitted the case was a hard one, but it was a little awkward to be asked to rescind a resolution. It might, moreover, create a precedent, and

The **Secretary** added that he had already had several applications of the same sort, and asked if hard cases were to lead to the making of bad laws.

Miss Paget replied that the mistake had arisen through the vacillation of the Board in fixing dates. The present request might be granted, as such a case could not again arise, as all dates would be definitely fixed.

The President, in answer, said that if they decided to commit this illegal act, a letter should be written to Cheltenham saying their request was under reconsideration, and this was agreed to.

Dr. Parker Young moved that the Rev. F. A. Richings, of Worcester, be censured for giving a midwife a certificate of good character two months after she had been convicted of larceny. A letter from this clergyman urged that he had put, or intended to put, " now," but as the certificate did not contain such wording, the vote of censure was carried, the President declaring the action " utterly disgraceful, if true."

Dr. Parker Young then moved for a reconsideration of refusals to recognise Charles A. Greaves, M.B., M.R.C.S. Eng., and Francis P. T. Hilliard, M.D., M.R.C.S., L.R.C.P., as teachers of midwifery. The first applicant was now on the staff of the Derby Union and Royal Infirmary, as physician and medical officer. The second applicant was now lecturer to the L.O.S. pupils at an Essex Infirmary.

Miss Wilson opposed the motion, as the Inspector's report showed the accommodation designed for lying-in to be inefficient and the management slack. With regard to Dr. Hilliard's statement that a teacher was required as there were " a good many cases every year," the Inspector had found six to be the average. Dr. Parker Young therefore reluctantly withdrew his motion, declaring the cases hard ones.

The President inquired as to the procedure with regard to revision of present rules before laying them before the Privy Council, and ultimately before the General Medical Council in May. It was agreed to send a circular to each member of the Board, asking them to make suggestions. Many had already been received from Borough and County Councils.

The Board then adjourned until Jan. 25th, 1906.

THERAPEUTICAL SOCIETY.

Meeting held Tuesday, November 28th, in the Apothecaries' Hall, London.

J. H. Jeffcoat, Esq., in the Chair.

Dr. W. E. Dixon spoke on the

BIO-CHEMICAL STANDARDISATION OF DRUGS.

The accurate standardisation of drugs is most important to the practitioner, but some only can be examined chemically, and crude drugs as opium and nux vomica are often used instead of their alkaloids, though opium sometimes contains more exciting narcotine than morphia, and the resins of nux vomica may interfere with the strychnine. Other variable drugs cannot be standardised chemically, as digitalis, squill, strophanthus, ergot and cannabis indica; of these also the active principles vary in strength and are sometimes quite inert. Of six specimens of liquid extract of ergot obtained from chemists, two had a moderate action, two were too feeble to be of any service, and two were quite inert. The bio-chemical standardisation would show, as with antitoxin, the real value of the drug in many cases: thus digitalis affects the hearts of frogs, causing death, but of tr. digitalis obtained from chemists one required twice, and another 2·8 times the amount of the standard preparation to cause death. The same occurred with tr. scillæ and tr. strophanthi of which one chemist's preparation required 9·7 times the amount of the standard tincture to prove fatal. These tinctures were chiefly procured by the chemists from wholesale houses. It is not probable that they were much changed by keeping as the standard tincture which was examined in May, and again on November 22nd, and was found not to be at all deteriorated. Chemists therefore should prepare their own tinctures and standardise them. The following resolution was adopted by the meeting: " That in the opinion of the Therapeutical Society, it is most desirable that those who are responsible for the British Pharmacopœia should take steps to insure the physiological standardisation of drugs, particularly of digitalis, squills, strophanthus, ergot, and cannabis indica."

Dr. C. O. G. Hawthorne spoke on drug idiosyncrasies in relation to an official dosage, showing that the British Pharmacopœial doses were likely to mislead a young practitioner, as the proper dose of a drug should vary in each case, not only according to the age and weight of the patient, which could be allowed for, but also with the peculiar idiosyncrasy of the patient for the drug, which could only be ascertained by experience. This was especially the case with opium, mercury and arsenic; but it also occurs with other drugs, and he recommended that cautions respecting these deviations from the prescribed dosage should be inserted in the preface to the next " Pharmacopœia."

France:

[FROM OUR OWN CORRESPONDENT.]

Paris, December 17th, 1905.

Acne of the Chin.

For a long time dermatologists have recognised the *role* played in the pathology of acne by lesions or troubles of the genito-urinary organs. There exists in this respect a special form of acne, remarkable by the region selected and the evolution of the lesions and which is only observed in women and appears to be in some way associated with certain genito-urinary troubles.

Professor Brocq was the first to draw attention to this particular form of acne. It is characterised by the fact that it is only to be observed in women, and the age or period of life at which it appears. It can be distinguished completely from juvenile acne, which generally disappears about the age of eighteen and the acne rosacea to be seen in women at the close of the menstrual period.

It appears between the age of twenty and thirty-five. The seat of the acne is the lower part of the face and principally the chin and the region of the mouth; differing in this respect from juvenile acne, which occupies the whole face and notably the forehead, the cheeks and the nose.

The pimples are few in number; frequently only two or three or at most eight or ten. They are indurated and voluminous, of the size of a large pea and of dark red; they are only painful when they begin to form. The development of these tumours is very slow, and they can persist during three or four weeks, at the end of which time they burst, giving issue to a small drop of pus or serosity, leaving behind an induration which lasts some days, or a small cicatrix and generally another takes its place, so that the affection is extremely tenacious and rebellious to treatment.

In interrrogating women presenting this variety of acne, it will be generally found that the functions of the gastro-intestinal tract are normal, on the other hand, almost always some trouble of the genital organs will be revealed such as metritis, salpingitis, uterine fibroma, retroversion, etc.

The treatment is local and general, the latter is naturally that of the predisposing cause. The local treatment consists in emptying the pustules by the fine point of a galvano-cautery and the following ointment applied, at night:

Precipitated sulphur, ½ drachm.
Salicylic acid, 10 gr.
Resorcine, 15 gr.
Vaseline, 1 oz.

Prof. Brocq employs a much stronger ointment which he leaves on from 5 to 10 minutes at first, and, if well borne, much longer—twenty to thirty minutes:

Camphor, 1 drachm.
Resorcine, 1 drachm.
Precipitated sulphur, 4 drachms.

Black soap, 1½ drachms.
Prepared chalk, ½ drachm.
Vaseline, 5 drachms.

In order to calm the inflammation produced by the above, he applies :—

Lanoline, 2 drachms.
Vaseline, 2 drachms.
Starch, 2 drachms.
Oxide of zinc, 2 drachms.

Locomotor Ataxy.

One of the most disturbing symptoms of locomotor ataxy is the lightning pains and for which several remedies have been prescribed. One grain of santonine three times a day has been recommended by some, mercurial injections by others, but where these latter have not given any result Prof. Raymond advises the trial of injections of nitrate of soda :—

Nitrate of soda, 1½ gr.
Distilled water, 3 drachms.

One syringe daily for 10 days. After ten days suspension the dose should be doubled :

Nitrate of soda, 3 grs.
Distilled water, 3 drachms.

At the end of ten days, another suspension for the same period, when the dose should be increased again:

Nitrate of soda, 4½ grs.
Distilled water, 3 drachms.

At the end of 40 to 50 injections, not before, the result is attained. The treatment rarely fails.

Germany.

[From our own correspondent.]

Berlin, December 17th, 1905.

Plastic Operation for Hydronephrosis.

The *Zeitsch. f. Chir.*, 8, 1905, contains an article on this subject by Dr. A. Laewen. For some years past Trendelenburg had suggested that in all cases of hydronephrosis the renal opening of the ureter should be made in another place in order to obtain an outflow of urine through it. Thirteen cases of transpelvic spur operation for hydronephrosis had been recorded. Of these nine had recovered completely, one with a small fistula, and in two a large fistula remained which rendered nephrectomy necessary later on. One patient died of ileus. With the exception of this latter case, in which the operation was performed intra-peritoneally, all were operated by oblique incision through the loin. The pelvis of the kidney was as a rule opened through the wall of nephrotic dilatation. At the close of the flap operation most operators drained and completely sutured the cyst wall, but Bardenhever fixed the cyst wall into the external incision and tamponnaded the cyst from the outside. In one case the operation was combined with that of fixation of a floating kidney, and in another with resection of a hydronephrotic sac.

Dr. R. Knorr has a note in the *Zeitsch. f. Gebruktsh and Gynnekol.*, Bd. L.V.,

The Causes of Pathological Urination in Women.

A very frequent cause of frequent micturition in women, he says, is inflammation of the neck of the bladder, in which frequent desire and pain in passing urine are the chief things complained of. The urine is clear and the sediment contains epithelium and leucocytes. Examined cystoscopically there is redness of the trigonum with swelling of the mucous membrane. In chronic cases papillary inflammation develops. The cause of the cystitis is either infection or venous stasis with hyperplasia. As regards treatment, he recommends washing out of the bladder, anæsthetization with a 2 per cent. solution of Beueaine and mopping of the parts with a 1 per cent. solution of silver nitrate. This method of treatment is contra-indicated in gonorrhœa and tuberculosis. In pericystitis the capacity of the bladder is generally reduced. By the aid of the cystoscope whitish yellow streaks are seen and bands that cast shadows.

Heyman, of Berlin, has also a paper on the same subject. The treatment he recommends is the following :—In acute cases washing out with a 3 per cent. boracic acid solution or a 1–10 per cent. solution of nitrate of silver or hydrang. oxycyanat 1 to 4,000, and internally urtropine, 3 grammes daily. He has had excellent results in chronic cases by means of the following method:—An Oberländer's urethral tube (No. 25 Charr), provided with an obturator, is introduced into the empty bladder. After removal of the obturator some urine is sucked out of the bladder by means of a probe armed with cotton. Then a straight Playfair's probe, armed with cotton and soaked in a 1 per cent. solution of nitrate of silver, is introduced through the tube into the bladder, which being done, the tube is withdrawn over the probe. The probe, with its cotton and medicated solution, is now in direct contact with the trigonum of the contracted bladder and the solution comes into contact with every part. The probe is then drawn rather abruptly. It is important that the cotton be firmly fixed on so that it does not come off in the bladder. Generally speaking, a few such applications are sufficient to bring about recovery.

In the *Archiv. f. Gynnekol.* Bd. LXXVI. I.H., Dr. Englemann, of Kreuznach, pleads for the

Conservative Treatment of Uterine Myomata,

in which he has obtained very good results. The treatment, he says, should be both symptomatic and general. For the checking of hæmorrhage the best means is systematic but not too tight packing of the vagina, followed by syringing with hot water. Internal medicines do not deserve much confidence ; the best is the fluid extract of hydrast. Canadensis, given from three days before the expected period until the second to the fourth day of the period. If pain is a feature he would not give narcotics, but make use of harmless means—camomile tea, rest in bed, and hot applications. For arresting the growth of the tumour, or for reducing its size, he recommends the subcutaneous injection of ergot kept up for years with massage, mud baths, and electricity. When electricity is used the sound must be in the uterine cavity and the current must not be less than 100 M.A. This treatment is contra-indicated with soft myomata and when inflammation exists. The surgeon must be quite sure there is no pyosalpinx before commencing massage. His mode of treatment, he tells us, is founded on his observations of 1,400 cases of the disease.

At the Med. Gesellschaft, Hr. Kirschner showed a man who had had

Paraffin Injections for Saddle Nose.

The man had been treated four years before, and soft paraffin had been used for the injection. Gradually a tumour developed at the root of the nose and this had to be removed. It consisted microscopically of connective tissue with grey cells and granulation masses. The speaker showed a number of preparations from this and other similar tumours, which had developed at the site of paraffin injections. From these he concluded that paraffin, both the hard and the soft variety, were liable to be completely absorbed, and that the permanence of any results obtained from the employment of paraffin was therefore very doubtful.

Hr. Eckstein conceded the possibility of absorption of paraffin after injection, but claimed that in the case of hard paraffin the rate of absorption was so slow that it need hardly be taken into account. He had frequently convinced himself of the permanency of the result.

Hr. J. Joseph had frequently touched up, or made after corrections, after injection of paraffin for saddle nose, the first result being unsatisfactory. In doing this, hard paraffin was met with in little pieces ; soft paraffin in much finer particles. He was of opinion that the injection should only be made in those cases in which the disfigurement was so great that the uncertain procedure could not make it worse.

Hr. Hirsch showed a little girl with

Tuberculous Ulcer of the Conjunctiva.

He proposed treating the case in the same way he had treated another similar case successfully, viz., by excision of the ulcer and transplantation of mucous membrane from the mouth.

Hr. Levy-Dorn showed

Four Series of Cinematographic X-Ray Pictures.

These represented (1) the movements of the wrist joint; (2) pronature and suppuration of the forearm; (3) flexion and extension of knee-joint; (4) apparent movement of the patella caused by moving the Rontgen tubes. Such plates were very difficult to take; they must be 18 by 24 c.m. in size, they must be changed with sufficient rapidity, and the object taken must be kept absolutely still.

Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, December 17th, 1905.

Fracture of Radius.

At the Gesellschaft, Eiselberg exhibited Storp's "Cuff" splint for the treatment of a typical radial fracture. In his eulogy of the instrument, he said it had one great advantage over all others in the treatment of Potts' fracture, viz., it secured immobility of the fragments without fixing the hand, which was an important factor in the treatment of these accidents.

To illustrate the importance of this point, he presented a female patient from Servia, who had suffered from a fracture of the leg. For some reason or other the patient's leg was put up in plaster of Paris, and the tibia fixed at right angles to the femur. In this condition she was confined to bed for three months till the knees got quite stiff, as the uninjured one involuntarily lay in the same position till both were fixed. On her reception into hospital, passive movement could not be effected, and operative means had to be resorted to. An orthopædic resection of both knees was performed to relax the contractions, and now the patient can move about with the assistance of two sticks.

Bum, in criticising the treatment, agreed with Eiselberg that the instrument had great advantages in this respect. In looking over a quinquennium of these accidents, he found that he had had 66 radial fractures under treatment which were undoubtedly *in loco classico*, and which had to be treated mechanico-therapeutically three-and-a-half to ten weeks after the accident. If such an instrument could avert this functional perversion, it was to be highly commended to the profession as a great advance over past treatment.

Perforation of the Vermiform Processes.

Albrecht next showed two hardened preparations taken from two infants where perforation had taken place, producing purulent peritonitis. In searching the literature for similar cases, he could only find one in common with his subject, which he found in an inaugural address given by Bamberger on appendicitis in the young. When we remember the frequency of rhinitis, pharyngitis, bronchitis, and pneumonia at this tender age and the amount of morbid secretion and exudation swallowed with these bacteria, one can hardly wonder at the result, though few apparently have noted this condition present.

Our wonder still increases when we consider the number of other factors present which we attribute to the production of this lesion, such as change, or unsuitable food, injury, repeated chronic catarrh of the bowel, etc., which are credited with producing the disease in adults. These conditions often go on for years without much harm to the young, if we can judge from the cases recorded in medical literature.

Methæmo-globin-æmia.

Albrecht also showed preparations taken from cases of methæmo-globin-æmia which had proved fatal after the use of potassium chlorate. The toxic effects, he said, were typically displayed in a male child, æt. 3, that was admitted into hospital about the beginning of October, suffering from pertussis. It was discovered that tubercle was present in the lung during the treatment, but about the end of October he took chicken pox, which complicated the treatment. On November 11th, a catarrh of the bowel, with stomatitis appeared, and, to crown all, the child was reported to be suffering from rubeola on the 14th.

We now come to the important part of the subject. About two days before the child's death it was given 0·5 gramme of chlorate of potass in grammes 80 of water, with bismuth subnitratis. In all there would not be more than one gramme of the chlorate of potass taken. The throat was brushed with a feeble solution of tannin and resorzin at the same time. The pulse was small, 128 per minute, respiration rapid and temperature as low as 35·9 before death.

The *post-mortem* revealed a variety of morbid changes. The right lung had caseous concretions at the apex, chronic tubercular deposits in the bronchial lymphatic glands, bronchicetasis throughout the entire substance of the lower lobe of the right lung with large caverns here and there; the liver was very fatty, the spleen increased, catarrh in the mucous membrane of the bowel, and lastly Methæmo-globin-æmia.

The peculiarity of this case was the small amount which produced such toxic effects. According to Mehring full doses of chlorate of potass may be given without observing any morbid phenomena; but in toxic conditions fever, dyspnœa, and a reduction in the alkalinity of the blood may be observed. There are strong reasons for believing that these causes were operative in producing a sudden termination, which can only be explained as an idiosyncrasy in the patient.

Teleky said it was now many years since the toxic action of the chlorate of potass has been acknowledged, which has led to the disuse of the drug in Vienna. This is another confirmation for its banishment.

Schopf related another case he had, which died suddenly with all the symptoms of methæmo-globinæmia after simply gargling with chlorate of potass.

Reitter said that chlorate of potass was not allowed to be used in Schrötter's clinic.

Neurath thought there was something strange in our logic, when we compared the small number of toxic cases with the frequency of sales in our apothecaries, as chlorate of potass was bought freely without any restriction, notwithstanding the toxic accidents observed in the profession. He would suggest that the drug be confined to the list of poisons.

Grünfield related another case that came into the syphilitic department of the Poliklinik. For three weeks he had received a gargle with 15 grammes of chlorate of potassium, but finding it ineffectual he swallowed a third of it besides using a powder of 2 grammes of potass, and had suffered no bad effects.

The Operating Theatres.

TOTTENHAM HOSPITAL.

Operation on a Case of Phlebitis Umbilicalis.—Mr. H. W. Carson operated on a child, æt. 3 weeks, who had been brought to him with the following history: The mother said that she first noticed a swelling in the right side of the scrotum when the child was twelve days old; the swelling had persisted without increasing in size; in other respects the child had been quite well. Examination showed that the swelling in the scrotum contained fluid and was reducible; the affected side of the scrotum had an unusual dark purplish coloration. The case, Mr. Carson said, at first sight seemed to be one of hydrocele of the processus vaginalis; but examination of the abdomen revealed the fact that that cavity was full of fluid. The abdominal walls were rigid and respiration was entirely thoracic. Further questioning of the mother elicited the information that the baby had been sick over-night and again that day, and had had no action of the bowels for twenty-four hours. The mother further stated that there had been no trouble with the cord. Peritonitis was diagnosed, and the child admitted. Laparotomy was performed at once, and a condition of advanced general peritonitis found, with much clear fluid mingled with flaky masses typical of streptococcal peritonitis. It was thought at first that the peritonitis might be due to some perforative lesion of the duodenum, but nothing of this sort could be found on most careful examination. It was then noticed that the round ligament of the liver was œdematous and a hard cord could be felt in that situation; the umbilicus itself looked normal. The abdomen was flushed out with saline solution, and then closed, provision being made for drainage. Mr. Carson referred to one peculiarity of the case in that the mother had sought help not for the grave condition of peritonitis, which had been entirely overlooked, but for the incidental swelling of the scrotum. Even had the case been seen at its earliest, it was doubtful, he thought, whether a better result would have followed, as these cases were practically always fatal. Phlebitis of the umbilical vein, which results from a septic condition of the umbilical cord, was rare, he considered, in this country, although even here the cord is not treated on truly aseptic principles. In Hong Kong, however, Mr. Cantlie has reported that 50 per cent. of the whole death-rate was due to this disease. Infection spreads up the umbilical vein to the liver, in which small multiple abscesses form, and, in addition, the peritoneum in the neighbourhood of the round ligament of the liver becomes infected and general peitonitris rapidly follows. The infection, Mr. Carson remarked, was streptococcal in all cases. Koplik, in his description of the disease, mentions that icterus is also a common sign; this symptom was not present in the case under consideration. The diagnosis was extremely difficult, though it would be easier if there were any concurrent inflammation of the umbilicus, and in those cases in which this sign was not present, the first indication of the trouble has been the onset of acute peritonitis, with its cradinal symptoms of pyrexia, vomiting, constipation, abdominal distension, and muscular rigidity. When peritonitis occurs in the first week or two of life the surgeon should be suspicious of the umbilical vein as the cause of the peritonitis. Of course, he said, no radical operation can be performed owing to the fact that the liver is already affected, and any attempt to prolong an operation, even if it could do any good, in a child of a few weeks old, would almost certainly be fatal, for babies stand abdominal sections badly. A case of this kind, he considered, emphasises the necessity of treating the stump of the cord on thorough aseptic lines at the time of delivery and taking care to prevent subsequent infection at this site.

The child made no improvement and death ensued four hours after operation. At the *post-mortem* examination, general peritonitis was present, the umbilical vein was thrombosed with a purulent clot, and multiple abscesses were found in the liver substance.

Aberystwyth has been placed on the list of contract and other appointments in respect of which medical practitioners are requested not to apply without first communicating with the secretaries of the British Medical Association.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 20, 1905.

SCIENTIFIC PEDAGOGY.

The greatest single quality alike in the nation and in the individual is the ability to "get there" the soonest and the greatest number of times. This quality often defies analysis and imitation, but remains a real and tangible asset to the possessor. It has been, and we all hope remains, a distinguishing trait in the character of the British—an asset as valuable to ourselves as it is dazzling and elusive to other nations. But this quality to be of permanent value requires as its complement the ability to "stick there," when once we have arrived, and it is a mere banality to say that this ability is challenged more strenuously every day. The methods by which we fight, the strategy and the tactics, need overhauling and renewing and reformation no less completely and thoroughly than our weapons. The stress falls, it is commonly admitted, more emphatically on our education and educational efficiency than on any other part of our national equipment, and though improvements there have been of late years, much in our methods of training the young is as obsolete as the Elizabethan blunderbuss or the Georgian cutlass. In fact, of our educational methods without exaggeration it may be said that among the leading nations of to-day there is no single one, excepting possibly Russia, in which so much that is archaic, traditional, redundant, and vicious remains. That this should be so illustrates one of the defects of our national qualities, namely, a preference for relying on that which has answered to indulging in experiments that remain to be justified. But the necessity for experiment, and for many changes that have passed beyond the experimental stage, is abundantly apparent; indeed, is vitally connected with the question of national supremacy and even of existence. In no department is this need for reform more obvious than in education. Educational programmes and methods have been continually in the melting pot for the last thirty years, and new and strange have been the forms in which they have emerged, but it would take a bold and even an obtuse individual to assert that anything like finality of shape has been reached. Emphatically it may be laid down that the one greatest desideratum in educational policy of the day is that it should be permeated by wise physiological and psychological ideals, so that that wretched experimentee, the child, or adolescent, should be delivered from the hand of the faddist who cares too much and the Gallio who cares too little, and given a chance of working out his own salvation. This great work must be undertaken by the medical profession. Not that there is any sign that it is unwilling to do so—on the contrary, the boot is on the other foot—but because it is imperative, that if order and comeliness are to emerge from present confusion, the functions and fitness of the medical profession, and of the medical profession only, to indicate the true line of policy must be proclaimed and insisted upon. And what is this policy ? It may be defined as a sane individualism ; a wise selection of the child for the method, and a wise adaptation of the method to the child. The question, indeed, is one of mental hygiene, a science that is in its infancy truly, but of which no one is more wofully ignorant than the average schoolmaster. The child's brain is an organ of the most delicate texture, and if it is to be brought to its highest maturity and to its greatest efficiency it must be nursed and trained and educated by those who realise something not only of psychology but of general physiology and pathology. The function of the school doctor does not, or should not, end in the diagnosis of ringworm or measles, with occasional advice about the drains thrown in. His right and proper place is that of mentor to the schoolmaster in the whole ordering of his school and the whole schooling of his pupils, to the end that not only the general hygiene of childhood may be rightly ordered on general lines, but that individual instruction may be adapted to individual needs. If we were asked the three directions in which medical influence is most needed in general, we should say in the prevention of education at too early an age ; in the prevention of overstrain ; and in the securing of adequate rest. Not that the doctor's duty should remain within such limits, but that these points call especially for his attention. With regard to education at too early an age, it is often pleaded in the case of poor children that the lessons do not amount to much, and that their mothers, being relieved of their presence at home, can get on better with the household work. These pleas show that the whole theory of juvenile education is utterly misunderstood. The natural teacher of the young child is its mother ; till the age of seven or eight it needs no " instruction " of the moral and physical. Attempts to teach such children in classes puts a tax on their attention to which at that age the little mind is not adapted. As to overstrain, it is often as much by method as by quantity that the mind is over-wrought. Stupid lessons puzzle, perplex, and discourage even the average children, and may cause irreparable harm even to the bright ones. Long repetitions are peculiarly baneful, and instead of training the memory turn the warder of the brain into a fume ; what wonder if the receipt of reason follows suit and becomes a limpet only ? The true training of the memory lies in associating cognate ideas and trains of thought, not in poll-parrot-like exercises of the speech-centre. Finally, as to insufficient rest. Dr. Acland has done well to call attention to the need for more sleep at our public schools. We reviewed his book on this subject in our last issue, and for details and diagrams we would refer our readers to the original work. Briefly it may be said that the hours of sleep at public schools are regulated rather by tradition than by physiology, and Dr. Acland's discovery furnishes one more proof that among the most pressing requirements of the day is a system of scientific pedagogy.

THE IRISH MEDICAL ASSOCIATION.

WE referred briefly last week to the deadlock in the process of reorganisation of the Irish Medical Association, brought about by the invalidation of certain of the proceedings at the recent special general meetings. We are not at present concerned with discussing the official carelessness or incompetence which has resulted in the present position, nor are we deciding by what legal means the Association must proceed in order so extricate itself. We prefer, at present, to direct attention to the fact that the reorganisation of the Association is still in the hands of its members, and is not fixed beyond recall. We hope that the illegalities which marked part of the proceedings at the special meeting on October 31st do not affect these articles which were passed unanimously, since in them are embodied certain measures which put the Association on a more business-like footing than it has heretofore enjoyed. Passing over these non-contentious questions, however, the main point still at issue is with regard to the constitution of the Council of the Association. On the one hand, there are those who think that the general meeting should be the governing body of the Association, and that the Council should be merely the executive to carry the will of the general meeting into act. On this view, the Council should be a small body, and should be elected by the general body of the members. On the other hand, some regard the county branches as the essential element in the constitution of the Association, and desire a Council which should be a Parliament of the branches. The latter view, as put before the recent special meetings, embodied itself in an article providing for a Council of forty-two members, viz., a President and an honorary secretary, elected by the members of the Association at large ; thirty-two members elected by the members of the Association residing in each of the counties respectively; three members elected by the members of the Association in Dublin, two by those in Cork, and two by those in Belfast. Such a Council has the drawback of being so large as to be unwieldy, and it would consequently be forced to delegate many of its powers to committees. We are glad to note, however, that only the Council can appoint temporary committees for the consideration of special subjects, or the transaction of specific business. It would, we fear, be impossible also for the finances of the Association to bear the strain of paying the travelling expenses of the country members of such a large Council, and this payment we regard as essential. It is out of the question to expect hard-worked country practitioners to give up not only their time, but their money to attend Council meetings in Dublin, and unless it be made possible for the country members to attend fairly regularly we fail to see how the Association is to be raised to its proper position in the country. There is, moreover, an additional drawback which has hardly received sufficient attention. No scheme of reorganisation can be satisfactory which leaves it possible for the Association to become representative of anything less than the entire profession in Ireland. It must be the organic body of the entire profession, a body of which every medical man in Ireland, be he in the Poor Law or the Asylum service, engaged in private practice or in teaching, may feel himself an integral part. Under the scheme we are discussing, however, there is grave danger that the Association may degenerate into a Poor Law Service Association alone. The majority of the medical men resident in the counties of Ireland are engaged in the Poor Law Service, and as Poor Law reform is at present the question most prominent in medical politics, it is almost certain that the whole number of county representatives would be Poor Law men. Of the officers and city representatives, it is likely that some at least would be in the Poor Law service. It results, therefore, that five or six members at most would be as large a representation as non-Poor Law men could hope to obtain, although they constitute nearly two-thirds of the profession in the country. If this condition come to pass, the Association will lose its power as the representative body of Irish medicine, and will equally lose its power to promote the very cause Poor Law men have at heart—reform of the conditions of the Poor Law Service. We believe that the Poor Law medical officers themselves will be the first to admit that they cannot hope to stand apart from their professional brethren, and we are glad that there is still opportunity to reconsider the injudicious proposals tending in that direction.

THE KING EDWARD'S FUND AND HOSPITAL AMALGAMATION.

The proceedings of the King Edward's Fund are this year characterised by a fresh move in the campaign against the smaller hospitals. The reasons for this policy are not all on the surface, and any great public body, such as the Fund in question, should be prepared to announce and to justify fully proposals that involve issues that are in many cases delicate, complicated, and vital, both to general and to individual interests. Last year we examined the Fund's proposal to amalgamate the Royal National, the Royal and the City Orthopædic hospitals. We showed that by taking refuge in such a combination it would be possible for a badly managed hospital to conceal financial mismanagement. In the case of the Royal Orthopædic Hospital in Oxford Street, the sale of the freehold site of the hospital premises we condemned as an absolutely indefensible proceeding from a business point of view. At the present moment the site is covered with valuable flats and business premises, all of which could have been erected without the hospital being robbed of its only endowment. The funds of the Royal Orthopædic as well as its fortunes are now irrecoverably intermingled with those of the Royal National. The sale of the Royal Orthopædic premises was opposed by a strong minority, who forced up the sale price by £12,000, and whose objections have never been satisfactorily answered. The King's Fund pressed on their scheme of amalgamation and have never shown that they duly considered the pros and cons of the sale which they strongly urged. Even now it is not too late to hold a formal inquiry into the whole facts connected with the sale of the Royal Orthopædic Hospital premises. We also showed that a serious injustice was involved as regards the medical staffs of the amalgamating hospitals. It was a condition imposed by one of the contracting hospitals that none but Fellows of the English colleges should become members of the honorary medical staff. That condition at once excluded one or more of the existing staff. The City Orthopædic Hospital wisely stood aloof and refused to sink its individuality in amalgamation. Had it consented several of its members would have been thrown out of their hospital posts by the unjust and intolerable rule which directs that no surgeons with Scotch or Irish qualifications need apply. From the fact that the City Orthopædic Hospital has now consented to the amalgamation scheme, it may be safely inferred that the objectionable exclusion of Scotch and Irish Fellows has been abandoned. In that case the King's Fund will have indirectly achieved an important advance towards the removal of a standing class privilege that now disgraces the administration of all the great London and many of the provincial hospitals. If the throat hospitals amalgamate it is to be hoped that the King Edward Fund will insist upon the absence of any such unjust provision in the conditions of tenure of honorary medical staff appointments. It is to be hoped that the Fund will not stop at this point. If it be unjust to exclude gentlemen holding Irish and Scotch qualifications from the small hospitals it is none the less indefensible that they should be *ipso facto* debarred from the large institutions. By the existence of this degrading monument of class unionism many a brilliant man has been deprived of opportunities to which he has been entitled by his character and attainments. That, possibly, was the intention of the persons who first framed the excluding regulations. It is certain, however, that neither the public nor the Governors of medical charities appreciate the injustice they are called upon to maintain and to perpetuate. Public education upon this point is urgently needed, and we understand it is the purpose of the Scotch and Irish graduates and diplomates Associations to thresh the matter out. It has always been more or less of a mystery why the representatives of the Irish and Scotch colleges in the General Medical Council have never moved in the matter. Speaking generally of the King's Fund, we have nothing but praise for its energy and comprehensiveness, in spite of a few minor defects which we have felt it our duty to point out. Many attempts have been made, and probably will continue to be made, to capture the various funds on behalf of this, that, or the other interest. In the long run, however, we are happy to believe that wisdom, justice, and information will govern the counsels of the King Edward VII. Hospital Fund.

Notes on Current Topics.

Medical Babel.

In an address last summer Dr. Maudsley deplored the growth, within the nominal confines of the English language, of a strange and often barbarous scientific terminology which threatened to become so narrow and technical as to make it doubtful how far, in the future, two men not in the same speciality would understand each other. Bad as this verbal parasitism is over here, we have not yet attained to the complexity of our American *confreres*, who seem to revel in abstruse, cacophonous terms. An excellent skit on this baneful tendency occurs in *American Medicine;* we only regret that we are unable to transcribe it whole. "Some time since," we read, "a pimelatic, devalgate, oxyrhine individual with a setigerous face, wearing a prothesis ocularis and having a pince-nez suspended by a short concatenum, came to consult a doctor. Advancing with a peculiar festination and adjusting his perspicilla, he began thus—exhibiting the characteristic Yankee rhinolalia. 'I will proceed to expound my symptomatology. My nasarium is always turgescent; I am troubled with somniloquence, deginus, tabescence, segnitia cecutience, and hematophobia.'" The doctor after performing gastrodiaphany and glossoscopy, replies: "'In this case you are right. However, I deplore such autodiagnosis, especially in such a medical sciolist as you. Your approaching cecity will inevitably tend to a chronic meconophagism with terminal cacothanasia. I fear such a prognosis will be a powerful dacryagogue!" The patient's wife also suffered. "'My uxorial consort was ill continually from the critical matutinal nausea of the first tremesto, until the time when with conquassant tormina she was delivered, and then in addition she developed galacotpyretus in a few days. The baby was handicapped, due to a faulty omphalolysis performed by a medicaster who knew little of eyesiology.'" The doctor met the "nidicium" by prescribing a "medicamentum of lapactic, roberant, epulotie, detergent, catagmatie, abluent, and emulgent powers," as he did not wish to pander to the patient's "pharmacomania," and wished also to avoid "therapeutic neophilism." He tells his patient: "Observe a short jejunum, take a hot pedluvium, and a diurnal aprication." He is to take his "polycdrestus"—"a veritable catholicon"—to the "contiguous pharmacopolium." A quarrel ensues over the amount of the fee, and the doctor exclaims: "You are rather pachycephalic not to understand. Your mierocheilia betrays certain ethiopification. Do you take me for a hippiater or are you unfamiliar with medical deontology?" The patient makes a hasty exit before a "suppedaneous application" to his pygidium, which landed him in the street with a "descendant ansractuosity," and he proceeded on his way with "decided claudication." The whole of the original forms an excellent piece of fooling.

Aseptic Management of the Umbilical Cord.

We do not know what instructions are given to midwives with regard to the management of the umbilical cord in the new-born child, but it is probable that in practice she will imitate the method of many physicians who are content to use an ordinary piece of silk thread to ligature it with and a pad of gauze to cover the stump. Schell, of Philadelphia, argues in *American Medicine* that the infant is as much entitled to the benefits of asepticism as the mother, especially in view of careful study by Eroess of Budapest, who showed in 1891 that the process of separation of the cord is pathological in 68 per cent. of cases, and that in 45 per cent. of cases of fever in new-born children the cause was septic trouble about the umbilicus. Serious illness sometimes is produced, and even death was due to the same cause. Koplik describes the umbilical stump as an open wound which is liable to all the ordinary processes of infection. Even though normal in appearance after death the perivascular tissue may be found infiltrated and the arteries filled with thrombi. At autopsies in children in whom the cord appears natural parenchymatous inflammation of the liver, kidney, and spleen have been discovered, and even foci of suppuration in the joints. Schell himself uses the following method. When the child is born two pairs of hœmostatic forceps are placed on the cord and a cut is made between them. The child is now put aside till labour is completed, and then the stump and surrounding skin are carefully washed in 1-4,000 perchloride of mercury solution. With the scissors a cut is then made round the junction of skin and amnion, the amniotic covering and Wharton's jelly is stripped away from the vessels, and these are ligatured with sterile catgut. The stump is then washed with mercuric chloride solution again, dried with sterile gauze, and dusted with an antiseptic powder. Subsequently, the dressing is frequently changed, the parts washed in boric acid solution, and a fresh sterile pad applied. The author has never experienced any trouble from an umbilical cord thus treated.

Reminiscences of Dr. Thomas Addis Emmet.

ONE of the most interesting figures in medicine still with us is undoubtedly Thomas Addis Emmet, of New York, who has recently been persuaded to make public some reminiscences of his earlier days (*a*). How much medical education in America has altered since his student days is shown by the fact that, although he numbered Robley Dunglison and J. K. Mitchell among his teachers at the University of Virginia, yet he passed "a creditable examination" at the graduation in medicine, "without having dissected more than the sartorius muscle, without having written a prescription, or having attended an obstetrical case." Of the academic instruction of the time Dr. Emmet gives one specimen, which should render its author, Dr. Wallace, known to fame. The subject was hernia, the weather hot, the professor a man of twenty-one stone, and the lecture was as follows:—"When you come to operate for hernia you will find little you have been taught to expect, and I cannot now enter into a fuller explanation, but it is, in a nutshell, cut until you come to the gut, and you will be a damn fool if you cut it; good-day." Dr. Emmet's earliest professional work was as emigrant refuge physician in New York, and as illustrative of the horrors of an outbreak of cholera, he tells us: "On two occasions, when a larger number of bad cases than usual had been admitted, I found next morning all the patients and nurses had died since my last visit.

The New Government.

POLITICIANS and political papers of both complexions concur generally in the opinion that the new Cabinet is one which will command the confidence of the country. The Liberals are joyful, if not jubilant, and the Conservatives, if more discriminating, seem disposed on the whole to give the other side an innings, without anticipating any particular disaster. This being so, the supposition is that the General Election will give the Liberals a lease of power, and the country will watch with eagerness to see to what purpose they will put it. The appointment which concerns the medical profession most closely, of course, is that of the President of the Local Government Board, as the shaping of the public health policy of the country is in that Minister's hands. Sir Henry Campbell-Bannerman's choice of Mr. John Burns for this important appointment may be said to mark a stage in political history, for although Mr. Gladstone chose Mr. Broadhurst, a Labour representative, as Under Secretary at the Home Office in 1892, this is the first time that a working man—of the manual variety—has sat in the Olympian Council of the nation. That the choice showed imagination and enterprise no one will deny, but those who know Mr. Burns regard his selection as less of an experiment than it appears to others. Mr. Burns is a man of peculiarly virile force of character, and whatever he does he may be trusted to do thoroughly, whether it be talking to his constituents about their shortcomings, or knocking down a rough who insults a lady. Morally and physically he is fearless. Moreover he has had many years' experience of public work in Battersea and on the County Council, where he has fought many hard battles and won the respect of friends and foes alike. Whatever else happens, it may be safely predicted that the policy of the Local Government Board will be shaped with vigour, handled with firmness, and we should not be surprised if Mr. Burns does not do for his department what Mr. Chamberlain did for the Colonial Office—namely, lift it by the sheer force of his own personality into a prominence unknown before. If this healthful activity suffuses itself into the sanitary administration of the country we may yet have cause for rejoicing. At any rate, the Right Honourable John Burns will be a marked man, and he may depend on being the most keenly criticised member of the Government.

Chloroform and Late Poisoning.

IN spite of all that has been said and written of the dangers of chloroform, there is no doubt that it is as yet, in England at any rate, the anæsthetic agent in most general use. Hitherto we have been accustomed to think of the dangers of chloroform as occurring at the time of administration, and we have regarded it as free from some of the unpleasant sequelæ which have militated against a wider use of ether. If, however, the recent researches of Bevan and Favill (*a*) be borne out by other investigators, we have to beware of an after-danger hitherto disregarded. According to them, chloroform has the power of causing a fatty degeneration of the liver, kidneys, and heart, not unlike that met with in phosphorus poisoning. As a result of this degeneration and necrosis of the liver-cells, a toxæmia occurs which in severe cases may prove fatal. The occurrence of acetonuria, which has, of course, often been noticed, is one of the symptoms of this general

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(a) "Medical News," November 18th, 1905.

(a) "Journal of the American Medical Association," September 2nd and 9th, 1905.

toxæmia. The destructive effect of the chloroform is increased by certain predisposing causes, such as extreme youth, septic conditions and exhaustion from any cause. As Bevan and Favill point out, many cases arise which tax the wisdom of the anæsthetist in attempting to avoid on the one hand the toxæmia of chloroform, and on the other, the pneumonia of ether.

A Cardiff Medical Action for Damages.

Last week an important action, brought by a mining engineer against Dr. Skyrme and Mr. Lynn Thomas, came to an unsatisfactory conclusion by the disagreement of the jury. The claim was made on the ground of alleged negligence. In the present state of the suit comment cannot be made on various important professional issues involved, but certain facts may be recorded. The plaintiff injured his shoulder by a bicycle accident and went to Dr. Skyrme, who diagnosed dislocation, which he reduced by traction with a heel in the axilla. As crepitus was present Mr. Lynn Thomas was called in consultation, and the presence of complications was recognised. It was not considered desirable to manipulate for end to end approximation of fragments, but the elbow was secured to the side. Later a skiagram was taken and explained to the patient. The plaintiff alleged he was crippled as a result of negligence of his two attendants. At the hearing three surgeons, Mr. A. J. Pepper, Mr. W. Rose, and Mr. W. H. Battle, gave evidence on his behalf. Mr. Pepper thought there had been no dislocation in the first place; that the deformity should have been reduced at the time of the accident, and, failing that, open operation should have been performed upon the strength of the skiagram. Mr. Rose and Mr. Battle agreed. On the other side, Sir Thomas Smith, Mr. Mansell Moullin and Mr. Robert Jones approved diagnosis and treatment. The case for the plaintiff was that there had been no dislocation and no risk of gangrene and that the fracture had been improperly treated. The jury could not agree and were discharged. The costs of the trial have been heavy, and under the present issue each party bears his own costs. The defendants were represented by the Medical Defence Union.

Tuberculosis and Public Laundries.

One of the many improvements in the hygiene of the consumptive introduced in recent years, is the substitution of the paper for the linen handkerchief. This substitution is generally advised on the ground that the paper handkerchief may be destroyed as soon as used, while the linen handkerchief soon becomes dry, and the infective sputum is scattered freely in the form of dust. It is not to be forgotten that those brought immediately into contact with the consumptive are not the only ones to suffer in the latter case. Landouzy has recently taken the trouble to analyse the diseases for which laundry workers are treated in the Laennic Hospital (a). He finds that over a third of 1,202 laundry women treated during five years were suffering from pulmonary tuberculosis. These women, on entering their employment are usually healthy and robust young adults, but from their enforced living in an atmosphere of soiled linen they become easily infected with tuberculosis. In the sorting-room there is a constant atmosphere of dust rich in micro-organisms, renewed perpetually from soiled handkerchiefs, sheets, and pillow-covers. Tuberculosis arising from this source is avoidable, and a duty lies on the community to prevent the sacrifice of the health and lives of workers in laundries. We are sure that if the danger of sending infected clothes to the laundry were impressed on the consumptive patient or his friends, much of the present morbidity would cease. It is here that the thoughtful physician can do much good, as careful directions on the subject are easy to give, and not difficult to obey.

King Edward's Hospital Fund.

The King's Fund is evidently growing in popularity with the charitable as a means for distributing their gifts, for this year the income exceeded £100,000—the largest total it has yet reached. To this must be added the sum of £1,000 entrusted to the fund for allocation by the London Parochial Charities, so that altogether over £101,000 has been available for distribution this year. as opposed to £79,000 in 1904. The Council of the Fund having outlived some of their youthful follies—though, we fear, not all of them—are settling down to a fixed policy. As we have pointed out each year the Council of the Fund have a chance, hitherto accorded to nobody, of directing and co-ordinating the lines on which the hospital needs of London should move; and though they are gradually finding their feet, they have yet to go far before chaos and confusion give way to order and consistency. Perhaps the act of the Council that was most generally commended last year was the granting of £7,500 to the special fund for the removal of King's College Hospital to South London, and we note with pleasure that a further sum of £4,000 is now granted to the same object. The action of the King's College Governors in moving their small, inconvenient hospital from its expensive site in a district where it was not wanted to a freer and more commodious one where it was urgently needed was evidence of public spirit deserving of the fullest recognition. It would have been a thousand pities if the project had fallen through from want of money. The other hospitals who prefer tradition and private convenience to public necessity will, it is hoped, be left to fight their own way as far as special contributions are concerned. The needs of London to-day are not the needs of the London of a hundred or two hundred years ago, and if hospitals seek to serve the public, which is presumably their *raison d'être*, they cannot fail to recognise that centrifugalisation and decentralisation are urgent public necessities.

(a) "Presse Medicale," October 4th, 1905.]

Half Fees and Co-operative Companies.

A somewhat curious by-path of professional life was revealed last week in a London County Court. The plaintiff, Mr. P. W. de Santi, a well-known throat specialist, sued the defendant for thirty guineas, on account of an operation and subsequent attendance. As the circumstances of the case have been published in the *Daily News* and other newspapers, there need be no reticence in bringing it forward as a matter worthy of professional notice. The evidence for the defence showed that the Civil Service Association agreed with certain specialists to charge reduced fees to their members. Plaintiff appears to have been one of these contracting specialists and defendant as a member of the Association disputed the claim of thirty guineas on that ground. The latter, however, put himself out of court by admitting he had made an agreement for a certain fee to be paid for the operation. With the amount of fee and the steps taken to recover the same we are not here concerned. As regards the alleged arrangement with the Civil Service Co-operative Stores the innovation, if it exist, is certainly somewhat startling, and one regarding which the medical world would be justified in demanding further information. For instance, is there a *quid pro quo* in the transaction ? Are the names and addresses of contracting specialists published in the Stores' lists ? What do the unwritten laws of the profession say of such a proceeding, and what attitude will the General Medical Council and the Defence Societies take with regard to such a contract ?

Reuben Harvey Memorial Prize.

We desire to call the attention of our readers to a notice in our advertising columns regarding the seventh award of the Triennial prize—Reuben Harvey Prize. This competition is open to all students of the various schools of medicine, which are recognised by the Medical Licensing Bodies in Ireland, and also to graduates or Licentiates of these bodies of not more than three years' standing from the date of their Degree or License as the case may be. The prize is valued at £25, and will be awarded to the writer of the best essay, on a subject to be selected by the candidate, evidencing original research in Animal Physiology or Pathology, the essay to be illustrated by drawings or preparations.

PERSONAL.

We are pleased to add another name to the list of titles recently bestowed on members of the profession, in the person of Mr. Edgcombe Venning, F.R.C.S. Sir Edgcombe Venning, as he will be henceforth known, was at one time attached to the 1st Life Guards, but for many years past has enjoyed an extensive practice in the West-end of London.

The Nobel Prize, consisting of £7,700 in money, with a gold medal and an illuminated diploma, was formally presented at Stockholm on December 10th by the King of Sweden to Dr. Robert Koch, to whom it was awarded on account of his investigations in tuberculosis.

Dr. W. Hardcastle presided at the dinner of the Newcastle Clinical Society on December 7th, when Dr. Byron Bramwell was entertained. Earlier in the day their guest delivered an address on "Aphasia," before a large audience.

Dr. Thomas Wilson presided over the recent annual dinner of past and present students of the Birmingham University Medical School.

Mr. William Thorburn has been appointed to the re-instituted Lectureship in Surgical Pathology in the University of Manchester.

Dr. Liebig has been appointed Chief Physician in ordinary to the Emperor of Germany.

Mr. Reginald Harrison delivered the first William Mitchell Banks memorial lecture on Monday last at Liverpool University.

Mr. William Wright, D.Sc., M.B., Ch.B., F.R.C.S., has been appointed Lecturer on Anatomy at the Middlesex Hospital Medical School.

The Lords Justices of Ireland have conferred the Commission of the Peace for the Borough of Dublin on Surgeon Foy, M.D., of Cavendish Row, Dublin.

Mr. John Tweedy, F.R.C.S., President of the Royal College of Surgeons, England, has been appointed a Member of the Court of Liverpool University, for a period of three years.

Mr. Henry T. Butlin, F.R.C.S., has been appointed a Member of the Court of Governors of the University of Birmingham for a period of three years.

Dr. Garry Simpson, who recently resigned the appointment of medical officer of health for the Acton district, which he had held for eleven years, was, on Friday last, presented with a handsome case of surgical instruments, in token of the esteem of his late brother officials.

On January 11th, a congratulatory dinner will be held at Glasgow, under the presidency of Sir Hector Cameron, as a mark of appreciation of the recent titular honours bestowed upon Sir Thomas McCall Anderson.

It has been a matter of surprise in many quarters that so ardent and distinguished a Liberal as Sir Walter Foster has not found a place in the new Government.

Dr. A. W. Chapman has been appointed to the Commission of the Peace for the City of Manchester.

Dr. J. T. Ramsay, who has recently been appointed a Justice of the Peace for the Borough of Blackburn, is a native of Dundee.

There is great alarm in Madeira owing to two fatal cases of the bubonic plague.

The Berlin Museum has acquired a valuable collection of medical papyri, recently found in Egypt. They are said to include letters of Hippocrates, and to bear testimony to the interest with which medicine was studied under the Emperors.

During the last few days an epidemic, said to be cerebro-spinal meningitis, otherwise spotted fever, has broken out at Fincham, a small agricultural village close to Lynn, Norfolk. The disease has spread rapidly, and about fifty persons have been attacked.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

STRIKE OF ASYLUM NURSES.

The Glasgow Parish Council is apparently having troublous times with the nursing staffs of Gartloch and Woodilee Asylums. On Monday of last week a strike threatened, and was averted only on its being pointed out to the nurses that to leave insane wards unattended constituted a criminal offence. The cause of the dissatisfaction is said to be a readjustment of hours and duties consequent upon a report by the Commissioner of Lunacy adversely criticising the administration of the Parish Council, one of the strictures passed being that the nursing staffs were the most expensive in the country. The changes introduced by the Council involved a reduction of the number of the nurses, and they allege that the new rules mean that they will be on duty for eighty-four hours per week; the superintendent, on the other hand, asserts that they will work out at about seventy-six hours per week. It seems to have been thought that when Monday passed without the threatened strike a *modus vivendi* would be reached pending final settlement of the dispute, but on Monday five head nurses were dismissed at Gartloch, and one at Woodilee Asylum. To show their sympathy with their companions, the other nurses handed in their resignations, on the ground that the nurses dismissed had been so dealt with for having played the part of ringleaders in the agitation. The nurses who had been dismissed subsequently attended a meeting of the Glasgow Trades Council, and stated their grievances; the general feeling of that body was in favour of intervention on behalf of the nurses, and eventually a committee was appointed to deal with the affair. In the interests of the asylum inmates, a continuance of this unsatisfactory state of matters is greatly to be deprecated. Without pretension to any special knowledge of asylum administration, we think that even the lower figure stated by the superintendent, viz., seventy-six hours per week, involves a heavy strain on any woman engaged in the arduous task of looking after insane persons, and affords *a priori* reason for the belief that inquiry is needful. On the other hand, it is stated that the staff have hitherto worked under exceptionally favourable conditions, having had a new nurses' home recently erected, and being placed in charge of only nine patients each. The nurses, however, say that their hours of duty are from 6.30 a.m. to 8 p.m., that discipline is unnecessarily strict, and that they are not allowed to make pleasant use of their leisure. The intervention of the Trades Council does not seem likely to make for peace, judging by the language used by some of its members. To thrust oneself into a dispute, whether as arbitrator or partizan, because it affords an "opportunity to take down the Parish Council a peg or two," may be good politics, but it is certainly poor diplomacy, and any benefit which the Trades Council committee might have done will be greatly hindered by such an open expression of sentiment as that "anything that was to be got out of them (the Parish Council) had to be screwed out of them like the juice out of an orange." It would doubtless be a solace to the nurses, smarting under the feeling that they had been unjustly dismissed, to hear their masters called "reactionaries," and compared to "old women," but it seems to us a pity that these ladies should have dragged an outside body into their quarrel, and all the more so as several members of the Parish Council have publicly admitted that the nurses had grievances, of which accordingly there was every prospect of repeal.

BELFAST.

Candidates for an Infirmary Appointment.—Much interest centres round the election of a visiting medical officer for the Belfast Union Infirmary, in place of the late Dr. Lynass. The post is practically that of surgeon to the Infirmary, and gives immense opportunities of practice to an energetic man. It is worth £150 per annum, with students' fees as well. Dr. Lynass also held the post of medical attendant to Donore House, a country home for the workhouse children, at £100 per annum, but it is not certain that his successor in one appointment will necessarily hold the other. Some six or eight candidates are already in the field, and at present the strongest is considered to be one who already holds posts in the gynæcological department of the Royal Victoria Hospital, and at the Belfast Maternity Hospital. This has raised the question as to how far it is right that a man should hold several posts involving active work where there is a possibility that the interests of the different institutions may suffer. No rule on this point has ever been made at the Royal Victoria Hospital, though pressure has several times been brought to bear on candidates for junior posts to compel them to give up posts they already held. It is interesting to note the present position of the staff in this matter. Of the four surgeons two hold acting posts in children's hospitals, one in an ophthalmic hospital, and one has no other post. Of the four physicians none has any other acting post, nor have the two assistant physicians, while the two assistant surgeons are both on the staff of a children's hospital. The ophthalmic surgeon and his assistant, and the gynæcologist and his assistant all hold other posts.

Correspondence.

ARE THE PROBLEMS OF CANCER INSOLUBLE?

To the Editor of The Medical Press and Circular.

Dear Sir,—Certain recent publications from the Imperial Cancer Research Fund and elsewhere contain many statements about the views and conclusions of other investigators, without the least attempt at production of scientific evidences refuting the latter. The problem of cancer has been, and, if it yet exist, it still is a scientific, not a political problem. The officials of the Imperial Cancer Research Fund may not forget, when they are vainly condemning the views of other scientific men, that in recent times they themselves have devoted a good deal of work to a demonstration of the insecurity of the foundations erected by them in the First Scientific Report. Like many others, I am at a loss to know what their investigations have, in their opinion, really established as to the nature of cancer. In the First Report (p. 34) they described it in a footnote as a new organism morphologically and physiologically equivalent to the parent one which it was invading, inferring, I imagine, that its cells were embryonic or somatic.

Their present position would appear to be defined in the following lines of Dr. Bashford's lecture of 7th Dec., 1905: "In our investigations we have obtained evidence against all the explanations yet advanced as to the cause and nature of cancer, proof that cancer cells have not reverted to an embryonic or undifferentiated state, or that the growth and ceaseless cell-division of cancer resemble the intermittent growth and cell-division of reproductive tissue, or that the artificial propagation of cancer resembles the grafting practised by horticulturists in the propagation of plants and trees."

Now, I would examine these statements a little more closely. Cancer is or is not something within the life-cycle of the metazoan organism. Proof is still lacking that it is something outside that cycle. True, there have been suggestions made as to a sort of senile "reversion" to protozoa. I do not know whether these be still maintained along with the supposed "conjugation." If so, cancer would be something quite outside the metazoan cycle, for the only "protozoa" or unicellular organisms within it are the germ-cells, and perhaps in a modified sense the leucocytes (Gulland).

The three things in the life-cycle, and the only three ever found by embryologists, are germ-cells, trophoblast or asexual generation, and embryo or soma. By various observers cancer has been assigned to one or other of these things, and it is, perhaps, not needful to recite the well-known views of Dr. G. Beatson, Professor Farmer and colleagues, or those of German and other investigators, or, lastly, my own. The plain meaning of the words cited is, that cancer is not germinal, not trophoblastic, not somatic in nature or origin. Unless, therefore, it be indeed something quite outside the ordinary cycle, and the proof of this has still to be adduced, Dr. Bashford and his colleagues have succeeded in banishing cancer entirely from the realm of things real. But in none of their reports, in none of Dr. Bashford's articles, have they ever seriously considered, much less endeavoured to refute, the thesis that cancer is an irresponsible trophoblast. Perhaps it has been classed by them among those views "not worthy of serious consideration." However this may be, I will once more, with all possible emphasis, repeat the thesis.

Cancer cells and cells of asexual generations throughout the metazoa or higher animals share one feature in common with the protozoa, for the mode of digestion in all these is intracellular and by means of a ferment acting in slightly acid medium. (*vide* Otto von Fuerth, "Vergleichende chemische Physiologie der niederen Tiere," 1903, p. 253-258). On the other hand, an extracellular digestion, and by a ferment, trypsin, acting in alkaline medium, is restricted to the sexual generations of the higher animals or metazoa. Now, it has already more than once been stated by me that the unfolding of an embryo or sexual generation, with its ferment trypsin, would stay the growth of cancer. In normal development the equivalent of cancer—trophoblast—which has the minute structure and physiological properties of cancer, begins to degenerate at a certain period under the influence of the altered, now pancreatic digestion. These facts afford the possibility of testing by strict, scientific experiment the truth of my thesis, that cancer is an irresponsible trophoblast.

Certain experiments, made conjointly by Dr. H. Wade and myself in the laboratory of the Royal College of Physicians, Edinburgh, were undertaken to test this matter. With the aid of at least one small grant from the Carnegie Trust (to myself) they are still in progress. On my own responsibility I will now state certain among the things they have verified. There is no reason for setting a modest estimate upon the results, and it may be said with all emphasis that they have established completely experimentally the truth of my thesis of 1902, that cancer is an irresponsible trophoblast. The corollary to that thesis is that under the action of injections of trypsin the cells of, say, Jensen's mouse-tumour must degenerate. Now, working with this tumour in living mice, and with Dr. John A. Shaw-Mackenzie's prescription of trypsin, as prepared and dispensed by Mr. F. W. Gamble, and as with great generosity supplied gratis to us for these experiments by Messrs. Allen and Hanbury, it has been found a matter of perfect ease to destroy utterly the cells of this tumour in the living mouse without killing the animal. It is not said that we have yet "cured" a mouse of cancer, for as yet we have not attempted to do this. But we have had a mouse under treatment for as long as twenty-two days, and we have found after four injections of a certain dose spread over ten days that at the end of that time every cell of the tumour was in degeneration. As independently confirming the result, it may be stated that a certain competent Edinburgh pathologist gave this as his opinion a few days ago, adding that "the only normal cells are the leucocytes and the connective tissue stroma cells." This is, indeed, true. After only ten days of the treatment, fully half the tumour-cells are represented by shapeless masses of stainable matter, probably chromatin, and the whole of the remainder are mere skeletons of cells. Though not a pathologist, in my time it has fallen to me to be witness of many of the phenomena of degeneration which so often accompany normal development. But I have never seen anything to equal this. It is a ghastly, albeit a glad, sight to behold these skeletons of cells with their cytoplasm and nuclei sucked dry of something (? glycogen and albumin), which in life made up a good deal of their substance.

Further details regarding these experiments and their continuations will be published in due course, and without delay. All that remains to be said now is, that the investigators of the Imperial Cancer Research Fund have *not* obtained or adduced any evidence or proof whatsoever against the conclusion of the trophoblastic nature of cancer. Indeed, it is impossible, without a miracle, that they could do so. On the other side, the facts of embryology, pathology, and physiology go to show the truth of my thesis of 1902, and even now the experiments have demonstrated that Dr. John A. Shaw-Mackenzie and I were in the right, when less than a year ago we independently announced (*Lancet*, Feb. 4th, and 11th, 1905) that trypsin was the substance which would destroy the cancer-cell without injury to the individual. In advance I had a pretty shrewd suspicion how these experiments would turn out, but in the quick, sharp, decisive nature of their results they have exceeded my wildest dreams.—I am, dear Sir, yours very truly,

J. Beard, D.Sc.,
University Lecturer in Comparative Embryology.

Edinburgh, Dec. 18th, 1905.

Postscript.—On the day the twenty-two days "trypin-mouse" was killed, an untreated "control mouse," inoculated with the same tumour on the like occasion as the "trypsin-mouse," died of its cancer. Its tumour was about as large as the terminal phalanx of a man's thumb, while that of the "trypsin-mouse" was as big as—a lentil! Microscopically, this latter apology for a tumour was in shocking degeneration, shrinking away to nothingness, and perfectly harmless. This mouse, indeed, had practically been "cured" of cancer by nine injections of trypsin. These results are *the joint-work* of Dr. H. Wade and myself.

Obituary.

DR. JOHN HIGHET, OF TROON.

The death took place on the 11th inst., at South Beach, Troon, of Dr. John Highet, at the age of fifty-five. He was in his usual robust health up till a few days ago, but he contracted pneumonia, to which he succumbed, despite the best efforts of Drs. George M'Kerrow, Ayr, and H. J. M'Intosh, who attended him. He was educated at Ayr Academy and Glasgow University, of which he held the M.D. and D.P.H., and, with the exception of a short interregnum, was in practice for thirty years. About nine years ago, under the strain of a busy practice, his health gave way, and he left Troon for Perth, where he remained for several years, until his health was gradually restored. Afterwards he went to South Africa as medical officer on one of the transports, and on leaving the transport was employed by the Government at Pretoria in hospital service.

CHARLES JAMES AYRES, M.D.Brux., M.R.C.S.Eng. D.P.H.

We regret to announce the death of Dr. Charles James Ayres, of Welbeck Street, London, at the age of fifty-five. He studied at Westminster Hospital, and qualified as a licentiate of the Royal College of Physicians, London, and a member of the Royal College of Surgeons, England, in 1886. He took the M.D. degree at Brussels in 1888, and the D.P.H.Camb. the following year. He had been clinical assistant at the Hospital for Diseases of the Throat, Golden Square, resident obstetric assistant and assistant house surgeon at Westminster Hospital, house surgeon at the Royal Westminster Ophthalmic Hospital, and was a member of various scientific societies.

DR. J. J. POWELL.

We regret to record the death of Dr. John James Powell, which took place at Weybridge last week. while suffering from acute mania, he took morphia and cut his throat with a lancet. The deceased, who was in his forty-ninth year, was a very old resident of Weybridge, having succeeded his late father in the practice a quarter of a century ago. He enjoyed a large and influential private practice. He will be much missed by all classes in Weybridge.

NEW BOOKS AND EDITIONS.

The following have been received since the publication of our last list:—

Bailliere, Tindall and Cox (London).

Treatise on Orthopedic Surgery. By Prof. E. H. Bradford, M.D., and R. W. Lovett, M.D. Third Edition. Illustrated. Pp. 670. Price 21s. net.

Practical Sanitary Science. By David Sommerville, B.A., M.D., illustrated. Pp. 310. Price 10s. 6d. net.

A Manual of Physiology. With Practical Exercises. By Prof. G. N. Stewart, M.A., D.Sc., M.D., etc. Fifth Edition. With 595 Illustrations and Coloured Plates. Pp 929. Price 15s. net

Physical Diagnosis. By Richard C. Cabot, M.D. Third Edition. Revised and Enlarged and Illustrated. Pp. 577. Price 15s. net.

Lectures on Clinical Psychiatry. By Dr. Emil Kraepelin. Authorised Translation from the Second German Edition. Revised and Edited by Thomas Johnstone, M.D., M.R.C.P. Second English Edition. Pp. 352. Price 10s. 6d. net.

A Text-Book of Psychiatry for Physicians and Students. By Leonardo Bianchi, M.D. Authorised Translation from the Italian by James H. Macdonald, M.B., Ch.B. Illustrated. Pp. 902. Price 21s. net.

A. and C. Black (London).

Who's Who. 1906. Pp. 1,878. Price 7s. 6d. net.

Who's Who Year-Book for 1906. Pp. 132. Price 1s. net.

Chatto and Windus (London).

Herbert Fry's Royal Guide to the London Charities. Edited by John Lane. Forty-second Edition, New and Revised. Pp. 294. Price 1s. 6d.

J. and A. Churchill (London).

The National Standard Dispensatory. By H. A. Hare, B.Sc., M.D., C. Caspari, Jr., Ph.G., Phar.D., and Henry H. Rusby, M.D. Pp. 1,860. Price 31s. 6d. net.

Reports of the Society for the Study of Disease in Children. Vol. V. Session of 1904-5. Edited by George Carpenter, M.D. Pp. 341. Price 12s. 6d.

The Clarendon Press (Oxford).

Criminal Responsibility. By Charles Mercier, M.B., etc., etc. Pp. 232. Price 7s. 6d. net.

Archibald Constable and Co., Ltd. (London).

The Bacteriology of Peritonitis. By Leonard S. Dudgeon, M.R.C.P., and Percy W. G. Sargent, M.A., M.B., etc., etc. Pp. 243. Price 7s. 6d. net.

Henry Frowde (Oxford).

Counsels and Ideals from the Writings of William Osler. By C. N. B. Carnac. Pp. 277. Price 4s. net.

Henry J. Glaisher (London).

Electrolysis in the Treatment of Facial and Other Blemishes. By J. D. P. McLatchie, M.B., C.M. Pp. 19. Price 1s. net.

Government Printing Office (Washington, U.S.A.).

Index-Catalogue of the Library of the Surgeon-General's Office, United States Army. Authors and Subjects. Second Series. Vol. X. M.—Mnikhovski. Pp. 935.

Hirschfeld Bros., Ltd. (London).

Laputa: Revisited by Gulliver Redivivus in 1905. Second Edition. Pp. 124. Price 1s. net.

T. Werner Laurie (London).

With John Bull and Jonathan. By John Morgan Richards. Illustrated. Pp. 302. Price 16s. net.

H. R. Lewis (London).

Landmarks and Surface Markings of the Human Body. By Louis Bathe Rawling, M.B., etc., etc. Second Edition. Illustrated. Pp. 96. Price 5s. net.

J. B. Lippincott Co. (London).

International Clinics. Vol. III. Fifteenth Series. 1905. Edited by A. O. J. Kelly, A.M., M.D. Pp. 302.

Longmans, Green and Co. (London).

The Physiology and Therapeutics of the Harrogate Waters, Baths, and Climate Applied to the Treatment of Chronic Disease. By William Bain, M.D., M.R.C.P., and Wilfid Edgecombe, M.D., F.R.C.S. Pp. 300. Price 7s. 6d. net.

Transactions of the Clinical Society of London. Vol. XXXVIII. Pp. 263.

Macmillan and Co., Ltd. (London).

A Study in Nursing. By Miss A. L. Pringle, formerly Matron of St. Thomas's Hospital. Pp. 98. Price 1s. net.

A System of Medicine by Many Writers. Edited by T. Clifford Allbutt, M.A., M.D., etc., and H. D. Rolleston, M.A., M.D., etc. Vol. I. Pp. 1,209. Price 25s. net.

Rebman, Ltd. (London).

Biographic Clinics. Vol. III. By George M. Gould, M.D. Pp. 516 Price 5s. net.

The Scientific Press, Ltd. (London).

Notes on General Practice. By S. M. Hobblethwaite, M.D., etc. Pp. 78. Price 3s. 6d. net.

Simpkin, Marshall, Hamilton, Kent and Co., Ltd. (London).

Lunacy Practice. By William H. Gattie, F.C.I.S. Pp. 53. Price 2s. 6d. net.

Smith, Elder and Co. (London).

Ellis's Demonstrations of Anatomy. Twelfth Edition. Illustrated. Revised and Edited by Christopher Addison, M.D., B.S., etc. Pp. 851. Price 12s. 6d. net.

Williams and Norgate (London).

The Inflammation Idea in General Pathology. By W. H. Ransom, M.D., etc., etc. Pp. 354. Price 7s. 6d.

Medical News.

Royal College of Surgeons of England.

An ordinary meeting of the Council was held at the Royal College of Surgeons, on Thursday, the 14th inst., Mr. John Tweedy, President in the Chair. The death of Mr. John Croft, F.R.C.S., past member of the Council and of the Court of Examiners, was reported and a vote of condolence was passed to his widow.

New Examiners.—Mr. George Henry Makins, C.B., F.R.C.S., Surgeon to St. Thomas's Hospital, was re-elected, and Mr. William Bruce Clarke, F.R.C.S., Surgeon to St. Bartholomew's Hospital was elected a member of the Court of Examiners.

New Fellows.—The following members of the College, having passd the required examinations and conformed to the bye-laws, were admitted Fellows of the College: Cyril Beresford Howse, L.R.C.P.Lond., London Hosp.; Alfred Lucette Home, M.B.Lond., St. Thomas's; Ernest William Hey Groves, M.D.Lond., St. Bartholomew's; Frederick Augustus Hadley, L.R.C.P.Lond., King's College; John Francis Cunningham, L.R.C.P. Lond., St. Thomas's; Philip Roscoe Wrigley, L.R.C.P. Lond., Manchester; Harold Walker, M.B.Cantab., Cambridge and St. Bartholomew's; Eric Bayley, M.B.Lond., Charing Cross and London; Sidney Arthur Boyd, M.B.Lond., Charing Cross and London; Maurice Arthur Miller Fitzmaurice-Kelly, M.B.Lond., St. Mary's; Gerald Stephen Hughes, M.B.Lond., Middlesex Harold Balme, L.R.C.P.Lond., King's College; Joseph Burfield, M.B.Lond., St. Bartholomew's; Eardley Lancelot Holland, M.B.Lond., King's College; Charles Derwent Pye-Smith, M.B.Lond., Guy's; Harold William Wilson, L.R.C.P.Lond., St. Bartholomew's; Philip Edward Homer Adams, L.R.C.P.Lond., London and Oxford; Leonard Smith Talbot, M.B., New Zealand, Otago and London.

The following, who had not previously obtained the Diploma of Member, were also admitted Fellows:—Charles Coley Choyce, M.D.Edin., London; Robert Ernest Kelly, M.D., Liverpool; Norman Patterson, M.B.Edin., London; John Stephenson, M.B.Lond., Manchester and London; Garnett Wright, M.B., Edinburgh.

New Licentiates in Dental Surgery.—Wesley Barritt, George Henry Berwick, Thomas Tebbutt Blaxley, John Arnold Bowes, David Brewster, Samuel Milnes Buckley, Ernest Thirne Clarkson, William Cowden, John Arthur Crump, Henry Dagger, Geoffrey Dawson, William Thomas Dean, John Gerald Atkinson Fairbank, George William Geekie, Arthur Tidswell Hanson, Charles Hatt, Frank William Herbert, John Fulton Houston, Samuel Isaacs, Edmund David Reed Jacob, Albert James Jones, Bertram Charles Kirkman, John McBride, Fitz Julian Messer, Edwin Noyes Plummer, George Eugene Rice, Robert Rose, Arthur Thomas Spaven, Oran Edgar Starr, George Frederick Taylor, Edwin Spencer Tebbutt, Wilfrid Boyd Thompson, John St. Andrew Titmas, William Collingwood Tuck, Francis James Tuckett, Henry Johnson Weighell, Charles Weller, Joseph Hindle Westmorland, Alfred Owen Williams, Richard Stanley Witcomb, Albert Blagbrough Wolfenden, Howard Wordsworth.

Dental Practice.—Upon the recommendation of the Board of Examiners in Dental Surgery it was determined to recognise the Dental Practice of the Leeds Public Dispensary as fulfilling the requirements of Clause 7, section I., of the Regulations for the Licence in Dental Surgery.

Alteration of Fellowship Regulations.—A report was received from a committee appointed to consider the Fellowship Regulations, and, in accordance with their recommendation, it was determined to alter the regulations so as to allow candidates who have studied chemistry, physics, and biology elsewhere than at a medical school, to be admitted to the first examination for the Fellowship upon the same conditions as candidates who have studied at a Medical School.

Appointments.—Mr. John Tweedy, P.R.C.S., was appointed a member of the Court of the University of Liverpool for a period of three years. Mr. Henry T. Butlin, F.R.C.S., was appointed a member of the Court of Governors of the University of Birmingham for three years.

A letter was read from Mr. Henry Morris reporting the proceedings of the General Medical Council at their recent session, and the thanks of the Council were given to him for his services as the representative of the College in that Council.

New School of Clinical Medicine.

The London School of Clinical Medicine owes its inception to the growing demand that has of late years become evident for some centre in which the post-graduates, not only those engaged in general practice, but officers in the Army, Navy, and Indian Medical Service may obtain instruction in every branch of medicine and surgery from teachers of the highest repute. It is not uncommon for those desirous of keeping abreast of the latest discoveries to resort to Vienna and Berlin, or one or other of the American cliniques, to obtain instruction which ought to be available in the greatest city in the world. The Seamen's Hospital Society, with that commendable enterprise which enabled them to found and establish the London School of Tropical Medicine, probably one of the most successful post-graduate schools in the world, has agreed to establish in connection with this Society the London School of Clinical Medicine. This has attracted the following members of the medical profession, whose names are most eminent as teachers in the medical world:—Sir Dyce Duckworth, Drs. Fredk. Taylor, J. Rose Bradford, St. Clair Thomson, Sir Wm. Bennett, Prof. A. W. Mayo Robson, Messrs. Jas. Cantlie, A. Carless, Malcolm Morris, and J. Mackenzie Davidson. In addition to these members of the profession, who now become members of the honorary medical staff of the Seamen's Hospital Society, there are a large number of extra-mural lecturers who will take part in the instruction given to post-graduates in the School. A scheme of affiliation has been arranged between this Society and the Waterloo Hospital for Children and Women, Bethlem Royal Hospital, and the General Lying-in Hospital, whereby the teaching of every branch of medicine and surgery (except tropical medicine, which is taught at another branch of the Seamen's Hospital Society) is provided for. As special features in connection with the new School it may be mentioned that the equipment of the Hospital and the supply of material affords ample opportunity for investigations in anatomy and pathology on the cadaver. There is also a special department for the outdoor treatment of tuberculosis, and for the study of genito-urino diseases. The School will open for study on January 15th, and we trust that the effort will meet with the success it deserves.

The Polyclinic Annual Dinner.

The seventh annual dinner of that most useful and flourishing institution, the London Polyclinic, was held on December 8th at the Trocadero Restaurant. The chair was taken by Mr. Mayo Robson, who made an interesting statement of the position of the Polyclinic with regard to post-graduate education. The toast of the guests was responded to by Sir Douglas Powell, and also by Surgeon-General Keogh, head of the Army Medical Department. The latter spoke of the great value of the Polyclinic in the post-graduate instruction of army medical officers. Captain Haward Pinch, the energetic and able secretary of the Polyclinic, replied in a humorous speech to the toast of that body. There was a large attendance of members and their friends, including many ladies. An excellent musical programme was provided, and the artistes concerned were well received. The Polyclinic may be congratulated on an admirably organised and successful gathering.

Catholic University Medical School Dinner.

The sixth annual dinner of the Catholic University of Ireland Medical School took place last evening in the Dolphin Hotel. About 150 gentlemen sat down to dinner. Sir Christopher Nixon, M.D., occupied the chair. After dinner the Right Rev. Mgr. Molloy proposed the toast of "The Catholic School of Medicine," associating with it the name of the chairman. He said that at the present moment their school was the largest of the six medical schools in Ireland—so far as the number of its pupils was concerned. It had carried off for many years the highest prizes in the keen competition of the Royal University in every branch of medical science. It had a staff of professors and lecturers which for learning, for zeal, and for efficiency was not surpassed by any school in the Kingdom. They might claim that the fitness and capacity of the staff was proved by the extraordinary success of the students. They wanted that a school which had attained such a position for itself by its own efforts should no longer be treated by the State as the Cinderella of the nation. The Chairman, in responding, alluded to Dr. Molloy's remarks, and said that they had no opportunities of pursuing that work of research which was so important in the progress of medicine, and in the lives of those men to whom they entrusted the scientific work of the school. The time had come when something must be done. Dr. Anthony Roche proposed the toast of the "Past Students," which was responded to by Dr. Cox. Dr. Coffey proposed the toast of "The Present Students." Other toasts followed. During the evening a splendid musical programme was contributed by Mr. May's band.

The Royal University of Ireland.—Meeting of Senate.

A special meeting of the Senate was held on Friday, November 15, 1905, at which the recent disorderly conduct on the occasion of the conferring of degrees was under consideration. The following resolutions were passed:—"That we, the Senate of the Royal University of Ireland, whilst believing that the disorderly conduct of some of the graduates and undergraduates at the conferring of degrees on October 27th was most reprehensible and deserving of punishment, feel that, in view of the legal opinions we have received as to our powers, it would not be advisable for us to take any action with regard to that past conduct. The Senate feel, nevertheless, the urgent necessity of obtaining powers to deal with all matters connected with the honour and discipline of the University, and therefore request the Chancellor to approach His Majesty's Government and ask them to take such steps as may be found necessary to obtain for the University the needful powers."

Royal College of Surgeons in Ireland.

Fellowship Examination.—The following candidates having passed the necessary examination have been admitted Fellows of the College:—R. W. Burkitt, L.R.C.S.I., L. L. Carlos, L.M. & S. Madras University; H. H. B. Cunningham, M.R.C.S.Eng.; and T. A. Dillon, L.R.C.S.I. The following passed the primary part of the Fellowship examination:—J. J. McDonnell, Student R.C.P.&.S.I., and H. D. Woodroffe, student, T.C.D.

Royal College of Surgeons, Edinburgh.

At a meeting of the College held on Dec. 15th, the following candidates having passed the requisite examinations, were admitted Fellows:—Russell Gerald William Adams, L.R.C.S.E., Blenheim, New Zealand; John James Bell, L.R.C.S.E., Manningham, Bradford; Norman Duncan Buchanan, M.B., M.R.C.S.Eng., Zurich, Ontario; Thomas Marshall Callender, M.D., Sidcup, Kent; Khursedji Nasserwanji Karanjia, M.R.C.S.Eng., London; William Mackenzie, M.B., Edinburgh; Owen St. John Moses, M.D., Captain, I.M.S.; Jamshijd Dadabhai Munsiff, L.R.C.S.E., Edinburgh; William Ernest O'Hara, L.R.C.S.E., Edinburgh; William Guthrie Porter, M.B., Edinburgh; Walter Alexander Ramsay Sharp, M.B., Sydney; Herman Stedman, L.R.C.S.E., London, E.; Henry Young Cameron Taylor, M.B., Govan, and Alexander Wilson, M.D., Bearsden, Dumbartonshire.

Notices to Correspondents, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, to avoid the practice of signing themselves "Reader," "Subscriber' "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publications but as evidence of identity.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

L.F.P.S.Glasg. (Preston).—As a witness subpœnaed in a civil action you can insist on being paid your fees before giving evidence. This objection must be made before you are sworn in the witness-box. The usual practice for respectable legal firms is to tender a fee when the subpœna is served or at some reasonable time before the trial. In criminal cases no fee need be tendered, except in the case of witnesses being a great distance from the place of trial. In cases of summary conviction the question of costs rests absolutely with the discretion of the magistrate.

R.S.O.—Your best plan will be to place the practice in the hands of one or more of the well-known medical agents. The Argentine Republic is rapidly increasing in population and importance, although there is yet much to be done for the proper protection of life and property.

MR. L. G. I. is thanked for his communication, which, however, we are at present unable to utilise.

LEGAL v. MEDICAL FEES.

Four days were taken up by the patient and doctors' case at the Glamorgan Assizes, and in the course of it something like 150,000 words were spoken by judge, counsel, witnesses and jury. As the case cost about £2,000, the value of the words may be estimated at a sovereign for every seventy-five words. There is no other value, as the jury failed to agree.

We understand that the plaintiff in the action for damages against Mr. Lynn Thomas and Dr. Skyrme heard at the Glamorgan Assizes last week, and in which the jury disagreed, has instructed his solicitor to re-enter the case.

DR. MACKAY (Casa Colon).—Your communication is marked for early insertion.

F.R.C.S.Eng.—Suggestions from our readers are always welcome. That contained in your letter is useful and you will find it represented in our first number of the New Year, which will contain several new features.

AN ESSEX PRACTITIONER, is advised to give a trial of Diuretin (Knoll) in the refractory case referred to. The drug has now been sufficiently long before the profession to test its merits. It is a combination of sodium—Theobromine and sodium salicylate, and resulted from experimental researches by Schroeder.

J HARRISON.—Received and will be considered.

THE ROYAL NAVY MEDICAL SERVICE.

Notice is given in our advertising columns of an examination of candidates for admission into the Medical Department of the Royal Navy, to be held in London in February next. Prior application must be made to the Director General.

D.P.H. (Monmouth).—It has long been known that cats may convey diphtheria into houses, and thereby infect human beings. Some interesting investigations have been recently made into the subject by Dr. W. G. Barras, bacteriologist to the burgh of Govan. Two cats that had been ailing for some days were in close contact with two children who developed diphtheria. Organisms were cultivated from the cats' throats identical with diphtheria organisms of the human subject, while one of the cats later suffered from post diphtheritic paralysis.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, DECEMBER 20th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. P. L. Mummery: Clinique. (Surgical). 5.15 p.m. Mr. H. L. Barnard: Diseases of the Gall Bladder and Bile Ducts.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture:—Dr. G. Newman: Disinfection) Methods for Practitioners.

THURSDAY, DECEMBER 21st.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.)

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. H. Scharlieb: Some After-effects of Anæsthetics. (Post-Graduate Course.)

Vacancies.

Borough of Cambridge.—Medical Officer of Health. Salary £450 per annum. Applications to J. E. L. Whitehead, Town Clerk, Guildhall.

Bristol Royal Infirmary.—Pathologist, Bacteriologist, and Director of Clinical Laboratories. Salary £250 per annum. Applications to W. E. Budgett, Secretary and House Governor.

Cardiff Infirmary.—Resident Medical Officer. Salary £120 per annum, with board, washing and apartments. Applications to Leonard D. Rea, Secretary and General Superintendent.

Nottingham General Dispensary.—Assistant Resident Surgeon for the New branch, Hyson Green. Salary £160 per annum, with unfurnished apartments, attendance, light, and fuel. Applications to Secretary, M. I. Preston, Journal Chambers, Nottingham.

Nottingham General Hospital.—Assistant House Surgeon. Salary £100 per annum, with board, lodging and washing in the hospital. Applications to the Secretary.

Seamen's Hospital Society.—
Two Assistant Physicians.
One Assistant Physician or Surgeon for Diseases of the Throat, Nose, and Ears.
Applications to P. Michelli, Secretary, Seamen's Hospital Society, Greenwich. (See Advt.).

University of London.—Professorship of Protozoology. Salary £700 per annum. Applications to Arthur W. Rucker, Principal, the University of London, South Kensington, S.W.

West Riding Asylum, Wakefield.—Pathologist and Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, washing and attendance. Applications, to the Medical Director.

Appointments.

CLARKE, J. MICHELL, M.D.Cantab., Chairman of the Medical Faculty in University College, Bristol, and Professor of Medicine.

CLARKE, SIDNEY H., M.A., M.B., B.C.Cantab., Assistant Medical Officer to the Newport Borough Asylum, Caerleon, Mon.

CLUTTERBUCK, L. A., M.B., B.S.Durh., M.R.C.P.Lond., Honorary Physician to the St. Marylebone General Dispensary.

EDMUNDS, ARTHUR, M.B., M.S., F.R C.S.Eng., Surgeon in charge of Out patients at the Great Northern Central Hospital.

FAWCETT, EDWARD, M.B., M.S.Edin., Dean of the Faculty of Medicine at University College, Bristol.

HANDLEY, W. SAMPSON, M.S., M.D. Lond., F.R.C.S.Eng., Assistant Surgeon to the Middlesex Hospital.

HEATON, CHARLES JAMES M.R.C.S., L R.C.P.Lond., Honorary Visiting Surgeon to the Royal Sea Bathing Hospital, Margate.

MACLACHLAN, J., M.B., M.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Dornoch District of the county of Sutherland.

PITHIE, A. D., L.R.C.P. & S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Lymington District of the county of Hants.

POCHIN, F. L., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Fakenham District of the county of Norfolk.

RAY, JOHN HOWSON, Ch.M.Vict., F.R.C.S.Eng., Honorary Assistant Surgeon to the Manchester Royal Infirmary.

Births.

GALLIE.—On Dec. 16th, at Forest Lodge, Standford, Liphook, Hants the wife of Captain J. Stuart Gallie, R.A M Corps, of a daughter

GENGE.—On Dec. 16th, at Encombe, 89 Lansdowne Road, Croydon Catherine. the wife of G. Gilbert Genge, M.D., B.S.Lond., D.P.H Camb., of a son.

THOMAS.—On Dec. 10th, at 13 West Southernhay, Exeter, the wife of Dr. Raglan Thomas (formerly of Llanelly, S. Wales), of a son.

Marriages.

BAINBRIDGE—SMITH.—On Dec. 13th, at the South Croydon Wesleyan Church, Arthur Bainbridge, M.A., M.D., D.Sc., M.R.C.P., son of E. R. Bainbridge, Esq., of Stockton-on-Tees, to Hilda Winifred, daughter of Rev. Edward Thornton Smith, Wesleyan Minister.

PLAYFAIR—JOURNAULT.—On Dec. 12th, at the English Embassy Church, Paris, Hugh Playfair, M.D., of 7 Upper Brook Street, W., second son of Major-General A. L. Playfair, to Eva, only daughter of Monsieur and Madame Journault, of 52 Rue de Clichy, Paris.

SARELL—CAMPBELL.—On Dec. 2nd, at Christ Church, Constantinople (the Crimean Memorial Church), Philip Charles, eldest son of the late Richard Sarell, M.D., M.R.C.P., of Constantinople, to Ida, only daughter of John Alexander Dewar Campbell, of Bagot, Jersey.

Deaths.

CARTER.—On Dec. 14th, Thomas Albert Carter, M.D., F.R.C.P., of Shottery Hall, Stratford-on-Avon, aged 71.

WOOD.—On Dec. 12th, at No. 8 Harrington Gardens, South Kensington. Elizabeth Tealby, widow of William Wood, M.D , F.R.C.P., late of 99 Harley Street, London, and The Priory, Roehampton.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXI. WEDNESDAY, DECEMBER 27, 1905. No. 26.

Original Communications.

THE RELATIONS OF ANGINA PECTORIS TO A VASCULO-CARDIAC REFLEX, HAVING ITS ORIGIN IN THE ABDOMEN. (a)

By WILLIAM RUSSELL, M.D.Ed., F.R.C.P.
Assistant Physician to the Edinburgh Royal Infirmary.

THE historical aspect of angina pectoris was first alluded to. The disease was first described by Heberden in 1768, who regarded it as a spasm or convulsion of the heart. In 1799 Parry described the morbid anatomy as calcareous degeneration of the coronary arteries, an observation which was also made independently by Jenner about the same date. The view then was that degenerated vessels made the heart unequal to any sudden stress laid upon it, and that the interference with the blood supply of the organ led to "syncope anginosa." Parry recognised that not all cases presented the classical features of angina dolorosa, and described as angina the condition where merely cardiac oppression and anxiety were present. Allan Burns compared a heart with calcified vessel walls to a limb with a ligature round it; exertion in both cases rapidly producing exhaustion. In 1819 Laennec expressed the view that angina was a neurosis or neuralgia of the heart. The early recognition of cases departing from the typical agonisingly painful form of angina led Walshe to introduce the term "pseudo-angina," for such cases. In 1867 Nothnagel published a unique series of cases of angina, in which he definitely pointed out that the symptons were associated with, and due to, vaso-motor spasm; he gave the name *angina pectoris vasomotoria* to those cases. The vaso-motor spasm was induced in his cases by cold. Nothnagel had to some extent been anticipated by Latham, and by Brodie. Charcot about the same time pointed out the phenomena comprised under the term intermittent claudication. Boullay, twenty years previously, had recorded the first case of intermittent claudication in a horse, in which any effort beyond walking caused the limbs to become rigid and painful. The next epoch in the history of the disease began when Lauder Brunton discovered that the symptoms were relieved by inhalation of nitrite of amyl, which relaxed arterial spasm. Under the term angina were included not only the classical severe form, but others in which pain was not a prominent feature. Walshe's pseudo-angina had already been referred to; Sir William Gardner had also included under the head of angina an *angina sine dolore*, which was characterised merely by a sensation of anxiety and cardiac oppression. Douglas Powell recognised cases due to vaso-motor spasm and to primary and secondary organic mischief. The views of Osler Bramwell, Sansom, Gibson, and Oliver were also briefly referred to.

Coming next to his own views, Dr. Russell pointed out that angina was merely a symptom-complex, and no more a definite disease than dropsy. He thought it was convenient to divide cases into two groups according to their severity —*angina major* and *angina minor*. Angina might or might not have a morbid anatomy In the production of the anginous seizure the vaso-motor phenomena of the body and their relationship to arterial pressure were of great importance. There was a normal cordio-vascular reflex, having its origin in the abdomen. After food, and for a considerable part of digestion, there was an influx of blood into the vessels comprised in the splanchnic area; this drainage was balanced by contraction of the systemic arterioles, evidently of reflex origin, and was a physiological hypertonus of the vessels—a reduced size and thickening of their walls not invariably leading to a rise in the blood pressure. The normal reflex process was adapted to suit the digestive requirements; the reflex was exaggerated by a large meal of stimulating nitrogenous food, especially if alcohol also were taken. The additional rise in the blood pressure which such a meal induced had a two-fold origin: (1) The reflex mechanism mentioned above; and (2) the absorbed products of the rich diet and the alcohol directly stimulating vascular contraction, such contraction, therefore, was not a neurosis. In addition to these two factors as the cause of heightened blood pressure, it must be remembered (3) that recurrent arterial hypertonus and increase of tension is an efficient cause of arterio-sclerosis; and (4) that sclerosed vessels are particularly liable to hypertonus. Acting on the view that the exciting cause of the anginous seizure was an exaggeration of this vasculo-cardiac reflex along with arterio-sclerosis, he had tried with the greatest benefit the effect of restricting the diet in such a way as not to evoke the reflex in its most marked form. Cases were instanced in which anginous seizures invariably occurred just after a meal; in these, careful dieting had given most happy results. The clinical pathology of angina was illustrated in its simplest form by the, cardiac oppression and arterial hypertonic contraction which followed excessive smoking. In its developed form the two factors in its production were absorption from the alimentary tract plus instability of the vaso-motor centre, the unstable equilibrium of the centre being easily disturbed by emotion, or effort, while attacks might also be evoked by any irritation of the stomach or bowel, or even by palpating in the epigastric region.

(a) Abstract of paper read before the Edinburgh Medico-Chirurgical Society, December 6th, 1905.

The anginous symptoms resulted from *sudden* heart embarrassment, and in the vast majority of cases this was determined by hypertonic, or spasm contraction of arteries, and might occur with or without coarse anatomical lesion in the heart. This was the link which united all cases of angina pectoris.

APPENDICITIS REVIEWED. (*a*)

By R. P. CROSBIE, M.A., M.B., B.Ch., R.U.I.,
Extern. Surgeon to the South Infirmary, Cork.

If apology be needed for an address on appendicitis, it can be urged in the unique importance of the subject, which, after all these years, still remains *facile princeps* the observed of all observers, the most considered, the most debated, and possibly the least agreed upon in surgery; and to those of us who see much of it—and I must confess to association with over two hundred cases—to us who dig and delve in it, of paramount and engrossing interest.

It is on this much be-written theme that has already filled volumes, and doubtless in the future to prove the occasion of as many more, I will risk a few lines, and here I will quote for you a recent utterance of Howard Kelly, which, though it has nothing to do with appendicitis, is still, I think, germane to all modern surgical matter. He says, "As earnest thinking men, you will all at once agree with me that it is not so much the clever and the novel as the useful we should ever hold in highest esteem in our art, and especially in these days do I appeal to your judgment at a period in which we find ourselves literally engulfed in a chaos of new surgical procedures evoked by the great discovery of your fellow countryman, Lister. Now do we need as never before to investigate, to deliberate, to reject and finally to accept the good, and further, I would rather make all recognise and do the well-known right thing than affect some great discovery and attract wonderand applause." The position, in my opinion, is not yet understood. We are dealing with perhaps by far the most formidable disease in surgery. It is most dramatic in its onset. It has no incubation period. There is no weakening of the chains that bind us to active life, no faint premonitory rustling of the death wings; in the midst of our health and avocations it strikes us down. And considering the treatment of this dread lesion that threatens us with every mouthful swallowed, are not the profession still as confused and uncertain as the general public are phantastic and befogged as to its actions and limitations. Some there are yet, I fear, who would treat the disease with ice, or a poultice, or what not, and like Horace's rustic wait patiently till the river had run by, and so also the time for successful operation, and still the question is passed around, "Would you have your appendix removed?" "Would you?" as if it were a matter of easy choice.

No one, I take it, likes submitting to a serious operation, but in refusing do they understand the grave risk to their lives? Of course, it is an undoubted fact that some cases get well without operation, but it is a matter of common agreement that the great majority of these relapse, with greatly increased danger, if subsequent operation be undertaken. It was courageously and prophetically laid down at that former meeting in 1900 that operation should never be delayed beyond the second attack, and it should be of great moment to inquire if modern ideas have advanced beyond that position.

Those Horatian gentlemen would hardly agree with Keen's aphorism that the first indication in appendicitis is to call in a surgeon. But granted they have wisdom enough to adopt that excellent maxim, can a surgeon, or for that matter a physician, have to undertake a graver responsibility than to decide for or against operation in certain cases of appendicitis? And if the surgeon hesitates how natural it is for a conservative physician to postpone the evil hour. But how far is either justified? Let us glance at the statistics. The mortality of appendicitis in three London hospitals for the years 1892 to 1895 was from 20 to 27 per cent. and the death rate of cases treated in the London Hospital from 1898 to 1904 varied from 17 to 23 per cent.—all exceedingly high figures, giving a rough mean of 20 per cent. I wonder are these figures appreciated when operation is dallied with and put off for the favourable time that does not come. For one can tell at the outset what course the disease is going to take, for it is of common experience that cases commencing mildly run a severe course, and a lightening of any or all of the symptoms is no criterion of the progress of the case. So difficult and paradoxical is the interpretation of the symptoms that help from whatever source is keenly sought. Dr. Sherran, in his paper on cutaneous hyperalgesia in appendicitis, claims by the presence of this symptom in a certain area over the right iliac region to demonstrate increased tension in the appendix, and by its absence gangrene or perforation. But on his own showing the symptoms of resolution and gangrene, especially when, as often it is accompanied by cessation of pain, are here confounded just when one is looking for light and leading to distinguish between them.

A mortality of 20 per cent. practically continuing unaltered during this extended period, when medical and conservative methods were gradually giving place to operation with no better results, forces us to the conclusion that a radical change in our procedure and, treatment is necessary. Consequently we are driven back to the conclusion that there remains but one solution to the question, universal immediate operation on the establishment of the diagnosis in the hope of removing this present foul page from our surgical records and lowering these appalling figures. For it is estimated that such an operation should have a mortality of only 2 per cent., or, as some authorities put it, a little higher, that is slightly over the mortality of cases done in the quiescent period. Fulminant cases would of course raise this figure: our operation is done then at a time which some surgeons regard as absolutely safe. Kelly says the ideal time is a few hours from the onset, as one meets none of the difficulties and complications of a later period. Indeed, in advocating the early operation, I was ignorant of the fact that practically the whole strength of the American profession was at my back—no mean support when their work in appendicitis is considered.

Some surgeons are so alert about this early operation as to urge that night should be considered as day in preparation for it. Some would divide the cases into those seen in the first 36 hours and those seen later, with operation in the former and waiting in the latter and tiding over the attack. But with regard to this waiting, it is here one remembers the pregnant phrase of two convincing writers who almost in the same words give us their experience. I have never regretted operation, often its neglect. Mr. Bruce Clarke asks pointedly, are we to wait till the appendix is thoroughly septic; and one observer, obviously a bridge player, advises—when in doubt, operate.

(*a*) Being the Presidential Address delivered at the opening meeting of the Cork Medical and Surgical Society, on December 8th, 1905.

Then finally as to the advantages of immediate operation. It may be claimed that the operation is then safest because one can never foretell what cases will suppurate. The operation is simplest when there are no adhesions, the appendix is not matted and no abscess to open into. The patient is saved days of agony and exhaustion with subsequent long convalescence. In fact, it is a matter of a brief surgical illness with speedy recovery.

The liability to recurrence is obviated, and in later operations the appendix may have to be left behind, which is certainly unsurgical. Recovery from the attack does not necessarily mean recovery from the disease as is effected by early operation. The immediate operation obviates the risk of hernia, and the risk of intestinal fistula is almost absent.

To focus another view of the subject. Does it not appear strange that this functionless rudiment—for who attaches any importance to the lymphoid theory? —this little tag or coceal tail should occupy such an exalted place in the corporeal economy, and I think it is yet further to come into prominence when its close connection to some other diseases is demonstrated. And here obtrudes itself a burning question, the exact sequence and relationship of appendicitis to obstruction. The very means by which this obstruction is brought about in appendicitis is of difficult explanation. I think it is best illustrated by the analogy of a Littré's hernia, as it were—a small nip of the intestine causing such immediate and far-reaching results; both may be exampled by the vital ankylosis of joints of the older surgeons, and may be described as the stricken intestine insisting on a lethal rest. Obstruction *per se* suddenly seems to have disappeared from our hospital wards, and has it not more often than not left appendicitis in its place? Co-incident with the disappearance of obstruction have appeared cases of appendicitis, in fact, I have three such cases in view where obstructive symptoms entirely predominated, obscuring the diagnosis, and where one had pains to insist upon their true appendical origin. How important the distinction between such cases becomes may be appreciated when one of our treatments not so long ago consisted of deep, repeated massage.

The effect of this in a highly inflamed organ or an acute abscess may be left to the imagination. Support for this view may be claimed from the following passage from Mr. W. Cheyne's monograph in the *B.M.J.*, for March, on acute abdominal illness. "It is a very common mistake to look on the constipation of appendicitis as an obstruction, and make matters a great deal worse by violent purgatives or irritating and distressing enemata." Coming from such a source, this is support indeed.

These obstructive symptoms and the way by which they are brought about, to my mind, are often wrongly interpreted, the stasis and distention producing fixidity of one portion, with a subsequent volvulus which is purely secondary, which when seen is often triumphantly snatched up and exhibited as the primary cause and origin of the obstruction and thought to be quite unconnected with the appendix.

I will not weary you with two views as to how the volvulus is formed. Then in the lists of causes of obstruction in the text-books, see what prominence is given to intestinal adhesions and bands. I wonder how many of these bands are seen outside the cæcal fossa. I have never seen them, but often enough have seen them radiate from the appendix like the spokes of Ixion's wheel, and although these bands are seen almost touching the appendix, their presence in that neighbourhood is seldom accredited to the disease. Of course, it is a rare clinical fact, that an adherent appendix itself has caused mechanical obstruction. I do not wish to claim that every volvulus or band is to be regarded as due to that disease, but I do not think it going too far to suggest that the appendix be examined in either affection.

Mr. Battle and Mr. Corner in a statistical compilation of three years of abdominal mortality at St. Thomas's Hospital, give us the following instructive figures:—Appendix, 37 per cent.; obstruction, 24; intussusception, 15; perforation of alimentary canal, 11; pelvis and gynæcological cases, 6; abdominal abscess other than due to appendix, 3; remainder, 4.

He gives the place of honour to appendicitis, with 37 per cent., with obstruction a good second with 24 per cent.

If from what has been said it be shown that obstruction must disgorge a modicum of its victims, then by so much appendicitis still further augments its formidable death-roll. One more revolution is this tiny organ responsible for, which might be described as the passing of Primary Peritonitis, evidenced by its complete absence from the foregoing list. And where also has disappeared that cloak for diagnostic inaccuracy, "fæcal accumulation," whose seat of election in 90 per cent. of cases was peri-cæcal, and where the surgeon's knife has long since thrown light on its obscurity and traced home to the appendix.

I cannot leave my subject without reference to Weir's operation of appendicostomy, exploited by Keatley, which met with such a universal chorus of praise lately, not at its introduction, curiously enough, for its ingenuity and worth. It has been my privilege to see and take charge of a case done for the first time in Ireland, I think. Every novelty in the profession from the Rontgen ray to the serrefine stirs up exaggerated hope, but still this operation seems to give great promise. It is of the easiest performance. It affords, I might say, a second mouth, disclosing the remotest portion of the intestine, and owing to its sphincter is unleaking. It has already been proved to facilitate the treatment of such opposed conditions as membranous colitis and obstinate constipation, and I have seen the diarrhœa lessen wonderfully by lavage in the former affection.

I can recall the positive fascination the operation held for an Indian medical friend, who saw in it a possible salvation in epidemic dysentery, from which, he assured me, the natives died like flies absolutely without hope from any of the older methods of treatment. No need to mention its possibilities in hæmorrhage and ulceration of whatever kind or in operative procedures as a substitute for ileo-colostomy and ileo-sygmoidostomy.

But in this I think the surgeon has helped the physician, and in their hands I think in certain cases its possibilities for direct alimentation may prove yet its most enduring triumph.

THE

INSANE AND THE GENERAL PRACTITIONER.—II.

By THOMAS DRAPES, M.B., T.C.D.,
Medical Superintendent of the Enniscorthy District Asylum.

(*Continued from page* 646.)

Civil Responsibility.—Apart from the question as to the propriety of sending a patient to an asylum, the medical practitioner is sometimes called upon for an opinion as to the testamentary capacity of a patient, and not a few cases of wills contested in consequence of a doubt respecting the patient's mental condition at the time the will was made have to be decided in a court of law. In these cases the medical practitioner must exercise great caution, tact, and discrimination. That a man who manifests symptoms of mental derangement is *ipso facto* incapable of executing any legal document such as making a will, giving a valid receipt, &c., is an opinion which is probably more widely accepted than might be imagined. But it is far from being correct. Many insane patients, even when delusions are present, are perfectly clear in their minds as to the proper disposal of their property. And if their insanity can be shown to have no distorting influence upon their judgment and will in a testamentary act there is no reason why such act should not be regarded as valid. And it is just here that the faculty of discernment is most needed. Some authorities are averse to admitting such a condition as "partial insanity," and the statement that if a man is insane he is "insane to his fingers' ends," is an oft quoted platitude. But it is none the less a fact—and a matter of ordinary experience—that many persons who manifest symptoms of insanity of various degrees from mere eccentricity of conduct to positive delusion act in a large proportion of the ordinary affairs of life with perfect rationality and sanity. They often show more conscientiousness and good feeling than many of their sane brethren. And if any mental abnormalities which they show are clearly a thing apart from and outside any particular line of action on their part, incapacity *qua* that particular act cannot in fairness be assumed. It is quite different if a patient has delusions, say, as regards his near relatives, or as to the amount of property he has to dispose of, in which case the disturbing influence of such mental aberration on the act of will-making would be perfectly obvious; and a decision of *non compos* would be the only permissible one. But in many cases it is very difficult to come to a decision at all, and it will require all the acumen of which a practitioner is possessed to satisfy himself as to what verdict he will be justified in giving.

Criminal Responsibility.—Probably no graver duty can devolve on a medical man than to be called on to decide, or rather to aid a jury in deciding, whether a prisoner accused of a crime such as murder was responsible for his act or not. For, at the outset, the attention of medical men should be directed to the fact that the responsibility of a man accused or convicted of crime is a question which, under British law as at present in force, it is for the jury, not for the medical witness to determine. He must limit himself to stating his opinion as to what was the patient's mental condition at the time the act was committed, whether it was such as to deprive him of the power of discriminating between right and wrong, or to prevent him realising the "nature and quality" of his act. It is with respect to these cases that law and medicine have been so often found to disagree. One essential difference between the medical and legal view of insanity is that in estimating a man's mental condition medicine insists, and rightly insists, just as in the case of any other disease, on taking his whole history, personal and ancestral, into consideration. His hereditary antecedents, his own individual medical history so far as ascertainable, from infancy up to maturity, the occurrence of previous attacks if any, all these have a most important bearing on his present condition. The law, on the other hand, is very chary of admitting any medical evidence except as to the patient's mental condition at the time the particular act which is the subject of litigation was done. The writer some years ago had to give evidence in a breach of promise case where there was no doubt whatever that the defendant was insane at or about the time when the proposal was made. He had been in an asylum sometime previously, and had relatives who were insane. At the examination of the medical witness, however, the judge would not allow any information regarding the man's antecedents to be elicited. Again and again counsel made the attempt, but whenever he put a question bearing on this subject the words were hardly out of his mouth before a peremptory "Don't answer that!" came from the judge. This action on his part led to some very unseemly wrangling; in fact, eventually to quite a scene, between Bench and Bar. The result was as might be expected. The sympathies of the jury in such cases are, as a rule, with the lady, and with so much relevant evidence withheld, it might almost be said forcibly withheld, from their consideration, they had not much hesitation in finding a verdict for the plaintiff, and giving her the consolation of damages for her blighted affection. Such a course as was adopted by the judge in this instance may have been in his estimation admirable law, but could it appear to any fair-minded man as anything else but inconsistent with fair play, equity, and common sense? The plaintiff ought to have considered herself very fortunate to have escaped such an alliance; the ill-fated defendant was sent to the asylum on two subsequent occasions, and eventually died there.

The law has been slow in grasping the fact that insanity is due to disease, and therefore more specially belongs to the province of medicine. Judges on various occasions have not concealed their opinion that the man in the street may be quite as good a judge as a medical man as to the sanity of anyone, and at the trial of Oxford for firing at Queen Victoria, Chief Justice Denman said to the jury that ordinary observers were as able to form a judgment on this matter as any medical man. To medical men, and particularly to those of them who have made a special study of insanity, such an opinion seems to carry absurdity on the face of it; and it is a question whether even the man in the street himself would be ready to endorse it.

To cite another illustrative instance. In Oxford last year a case occurred where a clergyman, æt. 63, was accused of an indecent assault. The plea of insanity was put in, and two eminent alienist physicians gave evidence that the accused was suffering from senile decay, progressive deterioration of mind, and inability to manage himself, with defective will-power, and constantly recurring ideas of a perverse sexual character which were imperative and uncontrollable. Both medical witnesses stated that they would have granted a lunacy certificate under the circumstances.

The judge, in summing up, said:—"I wish to speak with great respect for the doctors called, but it is your duty to follow such evidence with a critical mind and judge it. The question is whether the prisoner knew the offence was wrong at the time it was committed. I entirely repudiate the idea that mere decay of the faculties is evidence of insanity, or that a person suffering from senile decay is not responsible for his actions. I ask you to exercise your common sense as men of the world."

The jury, after a short deliberation, found the prisoner guilty, and the learned judge passed a sentence of six months' imprisonment with hard labour. (Reported in *Brit. Med. Jour.*, Feb. 13th, 1904.)

It would doubtless be a revelation to his lordship if he were to walk through the wards of some of our lunatic asylums and see how large a proportion of their inmates are suffering from dementia—that is, insanity—due to senile decay, who are there because they are incapable of managing themselves, and who are utterly irresponsible for their actions. Insanity is admittedly (nowadays even by judges) of the nature of disease. That being so, "common-sense," that common-sense to which they are so fond of appealing, might suggest that medical men, whose minds are specially trained in the discrimination of disease, ought to be more capable than others who have had no such training of determining whether such disease exists or not in any particular case. But juries are constantly bidden by judges to disregard the evidence of medical witnesses however eminent, and are told that they are just as good judges as any doctor of a difficult medical question. And twelve men called together at haphazard, none of them, as a rule, possessing one shred of medical knowledge, are invited to "follow such evidence with a critical mind, and judge it." How can men who are almost absolutely ignorant upon a subject criticise and judge the views of an expert on that subject? In any other connection such an idea would be considered in its farcical absurdity as only appropriate to Gilbertian topsey-turveydom. Let us picture for a moment the situation if the relative positions of medical witness and judge were reversed. Suppose a medical tribunal—say a coroner's inquest—with an eminent legal authority called as witness on a legal question. And imagine, if we can bring ourselves to imagine, an almost impossible contingency—the medical president addressing a jury in some such terms as these :—"This is no doubt a difficult legal problem, and I have the greatest respect for the eminent lawyer who has given his testimony upon it, but I caution you against being led away by any evidence he may have given, which you must follow with a critical mind and judge, exercising your common-sense." Does this hypothetical case, ridiculous as it may appear, differ in the least in essence from what is almost an everyday occurrence in courts of law ?

Our judges are, as a rule, men of commanding talents, of eminently practical minds, and of absolute and unimpeachable integrity; men, in fact, of whom the nation is justly proud, but as regards this question of the import and value of medical evidence do they not still suffer a little from the amblyopia of prejudice ? Is not their mental vision, so clear and keen on most subjects, still a little blurred when medical testimony happens to come within its ken ?

Law is a notoriously conservative institution, clinging to "authority" and "precedent," and is slow to adopt modern ideas which replace, and in some cases revolutionise, old conceptions. Medicine, on the other hand, is a progressive science, greeting new ideas with a cheer, ready to put them to practical use for the good of mankind. For centuries insanity, like all other diseases at one time, was believed to be in some special sense a "visitation," "the hand of God," &c., *i.e.*, something which it was not possible to explain by ordinary laws. *Mais nous avons changé tout celà.* Modern research, physiological and psychological, has shown that insanity, although by far the most difficult and intricate of all the ailments that afflict mankind, is the result of structural disease or disordered functions of the highest nervous centres, and, while infinitely more complex, stands on precisely the same footing as such symptomatic diseases as asthma, jaundice, or neuralgia. Now it is this doctrine of insanity which the legal mind, steeped as it is in precedent, and in antiquated and even archaic forms of thought, has found it so difficult to assimilate. The old garments refuse to incorporate the new cloth, and so the ghosts of ancient superstition even yet haunt the august chambers of our Halls of Justice. As an example may be cited the case of a prisoner with respect to whom there is a doubt as to his ability to plead. If the accused remains silent, in legal parlance, "stands mute," the jury are asked to decide whether he is "mute of malice" or by the "visitation of God." Such phraseology in the present state of our knowledge is an anachronism.

Opposed as Law and Medicine may be, however, on some points, it is not without significance that in recent years the two professions have been on the whole tending towards a *via media* where their up till now more or less discordant views on the responsibility of the insane, by a process of give and take, and by repeated modifications, seem to be at least approaching an approximately similar standard, which is not without its effect in practice. That sensible minds on both sides are coming to see that it is desirable, in the interests, not merely of the professions, but also of the public, who are principally concerned, that common ground should be found where Law and Medicine can meet in harmony, is shown by the comparatively recent publication of such a work as "The Insane and the Law" (*a*), in the compilation of which representative writers of both professions have collaborated, with the result that an eminently useful book has been for the first time produced in which the legal and medical aspects of insanity have been accorded equal and impartial treatment. One passage from this work may be appropriately quoted here :—"There are certain matters . . . which have led the majority of medical men, as well as some lawyers of experience, to look upon the rules of law with regard to the Criminal Responsibility of the Insane as narrow and worthy of severe and hostile criticism. It is feared, indeed, that in the controversy which has arisen on these matters between the medical and legal professions—to use the words of the late Mr. Justice Stephen : 'Many things have been said which would have been better left unsaid' ; and it is thought with the same writer that 'in dealing with matters so obscure and difficult, the two great professions of Law and Medicine ought rather to feel for each other's difficulties than to speak harshly of each other's shortcomings.'" This language, frank and forcible as it is, recalls to mind an exhortation which we are told Cromwell once gave to a wrangling group of his Ironsides : "Brethren, I beseech you by the mercies of God, consider it possible that some of you may be mistaken."

We must in any case be careful that, while discovering the motes which impair the vision of our legal brethren, our own eyes shall be kept free from the beams which they on their side only too easily detect. For it must be confessed that not infrequently medical witnesses cut a sorry figure when under examination in the Law Courts. And this is almost certainly due to the fact that they do not take the trouble to inform their minds as they ought on the medico-legal aspects of insanity. There is but little excuse for ignorance on this head as the necessary information is readily procurable from text-books on the subject, as, for instance, the work already alluded to, a copy of which might well be on every general practitioner's bookshelf.

Marriage of Insane Stock.—On one very delicate question the advice of the family doctor is sometimes sought, though not at all as frequently as it ought to be, *viz.*, the propriety of allowing marriage between persons in either or both of whose families there exists an hereditary tendency to insanity. If there is insanity on both sides he should have no hesitation in absolutely condemning such a prospective union with all the emphasis he is capable of ; and even where the taint exists on one side only, especially if the heredity is strong and very near relatives affected, he should discountenance marriage as far as possible. Too frequently the mischief is done and everything settled between the parties concerned before his counsel is sought, if it be sought at all. Of course, if one of them has a clean bill of health and is of robust constitution, physical and mental, his or her prepotency may ensure a healthy offspring. But marriage between persons who come of, say, an insane and a consumptive stock, is at best a highly dangerous experiment, and is pretty sure to end in disaster. Such unions are, no doubt, largely responsible for the increase of insanity, and as long as the general public are as reckless as they have been up to this in their action as regards this most important of all factors which concern the welfare of the race, the same calamitous consequences will ensue. This recklessness is more often than not the result of ignorance ; they really "know not what they do." And the medical practitioner might, if he would, do a great deal to enlighten that ignorance, and educate the public by degrees on this momentous subject. Hardly a week passes without some terrible domestic tragedy being recorded in the daily press, where the lives of innocent children, often several of one family, are cruelly butchered by some frenzied parent, who generally crowns his ghastly and inhuman act by suicide. In most, if not in all, of these cases there has probably been insane heredity, which, dormant perhaps till now, some stress of circumstances has awakened into unexpected activity. Better that such marriages had never been allowed to take place, that the poor child victims had never been born. It is surprising the little educative effect the frequency of such appalling incidents has upon the public mind, and how some small advantage which may be presented by marriage renders people absolutely blind to the fearful risk incurred by its consummation under such circumstances. Among the Irish peasantry marriage is too often a mere matter of business and bargaining ; and it has over and over again happened that a girl who has been once, twice, or even three times in an asylum, if she has a few acres of land or a few pounds "fortune," will find a man to marry her in the end. In these cases it is the land or the cash

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(*a*) "The Insane and the Law." By George Pitt-Lewis, Esq., Q.C., R. Percy Smith, Esq., M.D., and J. A. Hawke, Esq., B.A.

that he really marries, the girl is only thrown in because he cannot get them without her. And often the greatest unhappiness results, a condition which is irremediable. Against such practices the voice of the medical profession should be heard in unanimous protest, and in this they ought to be supported by the powerful influence of the clergy. In a well-ordered state such unions should be impossible ; they should be prohibited by law. There is, however, but small likelihood of such a regulation ever coming into force not, at least, until we reach the consummation of a hygienic Utopia.

FLUORESCENCE

ARTIFICIALLY PRODUCED IN THE HUMAN ORGANISM

BY THE X-RAY, BY RADIUM, AND BY ELECTRIC DISCHARGES, AS A THERAPEUTIC METHOD. (a)

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The therapeutic method outlined in this paper and in previous publications consists in the saturation of the human organism in whole or in part with a medicine endowed with the property of fluorescence (or phosphorescence), and in then submitting this patient to the action of X-rays or of the radium radiation or of high-frequency currents. It is, therefore, a combined treatment. I have termed it artificial fluorescence.

The sum total of my object was to develop light within tissue in the confidence that the well-known external effects of this agency might now be duplicated internally, and especially in the expectation that certain wave lengths of the visible spectrum, like the blue-violet and the yellow-green, might exert specialised effects. But it is also obvious that the wave lengths of the visible spectrum cannot be reasonably supposed to be the sole output and resultant of the absorbed energy of the X-ray and of the radium radiations. Effects, therefore, may be attributed to transformations into other wave lengths, as, for instance, the ultra-violet or even into the well-known secondary radiations, lower in wave length than the X-radiations, but still akin to them in their property of not being efracted and dispersed as are the violet and ultra-violet. These secondary radiations in their turn set up fluorescence.

The main point is that by reason of the medicine administered to the patient a new set of radiations is set up within his tissues, and that the most obvious of these radiations is light itself or closely akin to it.

In science it seldom happens that ultimate truth is arrived at all at once. Usually prior observations have preceded, a great number of experiments have followed, a final deduction has been made, and this itself may after all turn out to be wrong.

So it is regarding the subject of my paper, but certain it is that artificial fluorescence by radium and the X-radiations is founded on a solid physical basis, applicable to living human beings, and that the clinical results obtained at least increase the percentage of cures in many diseases.

History of Researches.

The steps leading up to the plan here presented of treating the entire blood system with a fluorescent substance and then submitting it to X-rays and to radium radiations are few but most interesting. They relate to a local use of the fluorescent substance by hypodermic injections or by topical applications, and to the use of the Finsen light as an excitant. With these methods I have had no experience, since my object has been not alone to affect superficial skin areas as in lupus, but rather to affect deeper areas like cancerous tumours, tuberculous glands, and tuberculous lungs, carcinoma of the stomach, and chronic disease like malaria or general conditions like pseudoleukæmia. To accomplish this purpose, the medicine to be administered by the mouth must be harmless, but also fluorescent, and a radiation must be used which is able to excite fluorescence deep within the tissues. Obviously, the Finsen light radiation would not furnish the penetration required and topical administration would not reach the diseases desired. I therefore resorted to the Röntgen ray and to radium.

Natural Fluorescence of Tissues of the Body.

In 1845, Professor Brucke stated that the crystalline lens of the eye was fluorescent, and the aqueous humour less so. In 1855, M. Jules Regnauld, using sunlight, found that the cornea fluoresced slightly, the crystalline lens highly, and the vitreous humour less so. In 1895, Setschenow, of Moscow, in a series of careful experiments, corroborated these results. He observed that when the eye is brought into the focus of the ultra-violet rays, immediately the cornea and the lens begin to glimmer with a white-blue light. Dr. Henry Bence Jones (a) not only repeated these experiments on the media of the eye, but also, as a result of careful researches, made the very remarkable discovery that man and all animals possess in every part of the body a fluorescent substance resembling quinine. This substance he found to be an alkaloid and to be closely related to quinine. He named it "animal quinoidin." He found that this animal quinoidin was present uniformly in extracts of the liver, heart, spleen, lungs, kidneys, brain, nerves, muscles, cartilages, blood, bile, and humours of the eye. The fluorescent substance did not disappear from lenses that had been kept for months in glycerine.

Using a spark from a Ruhmkorff coil as a source of light, Jones determined distant fluorescence in a solution of one grain of quinine to 1,000,000 parts of water.

Dr. Chalvet (b) found that Dr. Bence Jones' fluorescent substance exists in various foods and even in wine, and is, therefore, probably not of an animal but vegetable origin.

In 1858, Drs. Edward Rhoads and William Pepper published (c) a "Contribution Toward Our Knowledge of the Pathological Changes in the Fluorescence of the Tissues." They confirmed Bence Jones' results, and then advanced the original idea, based on an examination of the blood in a number of cases, that "a close connection exists between the diminution of animal quinoidin and malarial diseases." They therefore gave quinine to increase the fluorescence of the tissues to its normal point.

In 1900, Dr. A. F. A. King (d), of Washington, D.C., resurrected these publications of Bence Jones and of Rhoads and Pepper, in connection with his theory and suggestion of placing malarial patients in the dark or in rooms with violet or purple window hangings. Dr. King bases his suggestion on his belief that the sporulation of the plasmodium of malaria cannot take place in the dark, but only in light and more especially in red light. This treatment corresponds, of course, to the red light or Finsen treatment of small-pox.

In 1900, Professor von Tappeiner (e), in conjunction with Dr. O. von Raab, tested the action of the fluorescent light of phenylacridin on infusoria. Paramecia in an acridin solution of 1 in 20,000 died in sunlight in six minutes, in diffused daylight in about sixty minutes, but if kept in the dark they were alive after 6,000 minutes, viz., after 100 hours. Von Tappeiner summarises the results of his and von Raab's experiments as follows (f) : "Light becomes highly injurious to paramecia in the presence of acridin, phenylacridin, eosin and quinine in solutions in which these substances in themselves (in the dark) are hardly, if at all, poisonous. This action of light is closely connected with the fluorescent quality of the substances named. The injurious power, however, lies not in the fluorescent light produced, but in the process of its production."

(a) Read at the International Electrical Congress of St. Louis in Section H, Electrotherapeutics.

(a) Proceedings of Royal Society, April, 1866, and "Lectures on the Application of Chemistry and Mechanics to Pathology and Therapeutics." London, 1867.

(b) "Gaz. Heb.," Second Series, Vol. V., 1868.

(c) "Pennsylvania Hospital Reports," 1868.

(d) "Vermont Med. Monthly," June, 1902.

(e) "Munch. Med. Wochen.," 1900, No. 1.

(f) Quoted from Freund, p. 319.

O. von Raab surmises that we have here a conversion of the energy of the light rays into chemical rays analogous to that of chlorophyl, which is also a fluorescent body, but with this difference, that this conversion is the cause of death to the paramecia, whereas to plants it is the condition of continued life.

Von Tappeiner holds that this kind of light action comes into play with those animal organs, skin, retina, blood and lymph serum, which have the capacity for fluorescence. He surmises, too, that the cause of the skin inflammation noticed by Wedding, in beasts fed on buckwheat, lies in the fact that substances get into the body which are capable of fluorescence.

Von Tappeiner concludes his article with the suggestion that fluorescing substances, by being applied to the part and subjected to light, may be employed in dermatology, just as eosin and other fluorescing substances have been empirically employed for the last ten years in photography as "sensitisers."

In 1901, H. Lieber, of New York, made experiments with agar solutions inoculated with common mould, and further experiments with grape and other fruit juices, and found that fluorescent substances, like solutions of fluorescin, eosin, or rhodamin, arrested fermentation in every case so long as the solutions were exposed to daylight, but that the fluorescent substances had no perceptible effect on the solutions when kept in the dark. These principles he applied to the preservation of foodstuffs.

In June and August, 1903 (*a*), and later on, I (*b*) published a plan of saturating the entire system by administration of fluorescent medicines and submitting parts or the whole of it to X-rays and radium radiations, after, however, recording a series of experiments on patients from January, 1900, onward. In November, 1903, was published (*c*) the experiments of Dreyer on "Light Treatment" by the method of "sensitising' tissues, already suggested by von Tappeiner. This article, brief but most interesting and important, was a *résumé* of a report of investigations made to the Danish Academy of Sciences in April, 1903. Dreyer adopted the plan which has long been used in sensitising photographic plates of adding to the bromide or chloride of silver solution certain substances which are generally of a fluorescent nature. Infusoria, bacteria and animal tissues thus impregnated and submitted to the action of the Finsen light were affected by the green to orange rays exactly, as without the use of the sensitising agency they would have been affected by the ultra-violet rays. The importance of this plan is evident, for it is the red to green rays of the arc lamp which easily penetrate tissue, while the ultra-violet penetrate but very slightly. By the Dreyer sensitising method the scope of the Finsen treatment for lupus, &c., would be greatly extended and simplified, the effect would extend more deeply, the area be more extensive, and the pressure device be unnecessary. Dreyer used principally erythrosin in a solution of 1 to 4,000, a solution perfectly non-toxic, except under the influence of the arc-light radiation.

The following table is most instructive. Using a 30-ampere lamp, a quartz and water-cooled vessel, and erythrosin, different rays of the spectrum were tested. Micro-organisms were killed in the time and under the conditions given.

The table shows that it is the yellow-green rays to which the micro-organisms are rendered sensitive.

Dreyer also sensitised animal tissues by hypodermic injections of erythrosin, so that the yellow rays, otherwise without effect, would now cause an inflammatory reaction such as is caused by the violet and ultra-violet rays.

Colour Filter Used.	Acting Rays.	Infusoria.		Bacteria.	
		Sensitised.	Normal.	Sensitised.	Normal.
Quartz	Entire spectrum ultra-violet.	10 sec.	100 sec.	60 sec.	80 sec.
Glass.	Visible spectrum.	10 sec.	9 min.	10 min.	10 min.
Solution, nickel, sulphate.	Red-orange, yellow, green, blue.§	10 sec.	13 min.	10 min.	10 min.
Blue glass, monothromic.	Red, orange, yellow, yellow-green.	10 sec.	70 min.	15 min.	Over 4 hours.
Acid potassium, double chromium.§	Red, orange, yellow-orange.	10 sec.	110 min.	25 min.	Over 9 hours.

Professor Neisser and Dr. Halberstaedter (*a*) review and amplify the work of Dreyer. Neisser makes the following remarks as to the cause of the action :—

1. The occurrence does not depend on fluorescence, because there are sensitising materials which do not fluoresce, and fluorescent materials which do not sensitise.

2. The occurrence does not depend on the absorption of certain rays, because there exists a number of fluorescing and non-fluorescing materials which absorb the same rays as erythrosin, and yet do not sensitise.

3. The process can not be accounted for by the formation of toxic substances in the sensitiser during the illumination, because if one first subjects a sensitising fluid to light, and afterward puts micro-organisms into the fluid, these germs are not killed.

Jesionek (*b*) discusses the therapeutic applications of fluorescent substances in various diseased conditions after the method of Tappeiner just referred to. The skin was painted with solutions of fluorescent substances and then submitted to sunlight, concentrated by lenses or not. A solution of eosin was most commonly employed. In cases of carcinomatous growths parenchymatous injections of 0·1 to 0·01 per cent. solutions were used.

In July, 1904, Gunni Busck (*c*) advocated exposing malarial patients, to whom quinine had been first administered, to sunlight, on the ground that quinine causes micro-organisms to be sensitive to light. I had already considered the possibility of this plan in my first publications and wrote : "As to sunlight, as an exciting cause of fluorescence, it is to be noted that light passing through a red screen, as, for instance, the blood, fails to excite fluorescence, while the X-rays and radium radiations readily penetrate this screen."

On the whole, the fact is well established that quinine solutions when subjected to light exert a deadly influence on some micro-organisms. Ullman has found that paramecia placed in solutions of quinine of 1 to 20,000 die only after standing about five hours in the dark, while they are killed in the course of eight minutes if placed in sunlight, and under conditions which usually have no deleterious influence on the paramecia.

What is Fluorescence ?

Fluorescence is the property which substances have of absorbing invisible or visible rays and giving out visible light. The fluorescent substance does not give out the same wave length as that which it receives. According to Stokes' law, it should give out a wave length of lower frequency, namely, the shortest wave length of the fluorescence spectrum is always of less refrangibility than the longest wave length capable of exciting fluorescence. Lommel (*d*) has shown, however, that solutions of fluorescin, eosin, and naphthalin red do not conform to Stokes' law, and Nichols and Merritt (*e*), in recent investigations, show that rhoda-

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(*a*) "Electrical World and Engineer," June 20th, 1903; "Med. Record," Aug. 8th, 1903.
(*b*) "New York Med. Jour.," Feb. 13th and 20th, 1904.
(*c*) "Brit. Med. Jour.," November, 1903.

(*a*) "Deutsch. Med. Woch.," Feb. 18th, 190.
(*b*) "Munch. Med. Woch., May 10th, 1904.
(*c*) "Amer. Jour. of the Med. Sciences."
(*d*) Poggendorff's "Annalen," Vols. CXLIII,, CLIX., CIX.
(*e*) The "Physical Review," July, 1904.

min, resorcin blue, quinine, chlorophyl and esculin also do not even approximately conform to this law. The fluorescence of quinin sulphate appears to be independent of the wave length of the exciting light.

Fluorescence and phosphorescence are much akin. The former last only so long as the exciting cause is maintained; the latter endures after the excitation has ceased. Substances like willemite exhibit both properties. According to Becquerel, fluorescence is only phosphorescence of short duration. Certain it is that fluorescence and phosphorescence are natural properties of living animal tissues.

Experiments.

Among liquid fluorescent substances may be named quinine, esculin, fraxin, eosin, fluorescin or uranin, rhodamin, cochineal, copper, potassium chromate, gentian, henbane, litmus, naphthalin red, paraffin, petroleum, vaseline, stramonium, tumeric indigo, safranin, pavlin, magdala red, thallin, resorcorufin and resorcin blue, and some salicylates.

It was quickly found that while the above substances were fluorescent to daylight, a great variation in their capacity for fluorescence existed when exposed to X-radiations and to radium radiations. Some substances non-fluorescent to sunlight are vividly fluorescent to the X-ray and to radium, and *vice versa*. Among those most fluorescent to sunlight and vividly fluorescent to the X-ray and to radium are quinine, uranin, fraxin, esculin and members of the petroleum series, like vaseline.

Experiments made with liquids in glass receptacles were valueless, because the glass itself is highly fluorescent to the X-ray and to radium. Radium radiations are, on the whole, superior to the X-ray in exciting fluorescence. Many fluorescent liquids absorb the X-rays or radium radiations and therefore cast a shadow corresponding to the ordinary density shadow in radiography. This would seem to constitute a new sort of skiagraphy.

Applying this principle, I caused a subject, Dr. W. E. Deeks, to take twenty drops of a 1 to 30 aqueous solution of uranin, and one hour later submitted the hand to an ordinary X-ray exposure. The negative and print obtained when compared to a control picture of the same hand under the same conditions, except as to the dosage of uranin, gave an X-ray picture immensely superior in detail and clearness. This was especially true of the osseous structure and would lead one to suppose that certain portions of the bony structure, when saturated with uranin, absorbed the X-ray to a greater extent than if the uranin had not been used.

Applications in Disease.

I employ quinine bisulphate in doses of from five to fifteen grains daily, according to the natural physiologic tolerance of the patient—fluorescin, a 1 to 30 aqueous solution, from six to twenty drops, three times daily, one hour after meals—esculin, from five to fifteen grains daily.

One patient has now taken, in treatment of an extremely obstinate case of lupus, ten drops of the fluorescin solution three times daily during the last three months, and, employing the X-ray, not only has his lupus healed over large areas, but also he has gained thirty pounds in weight in the three months. Both in hospital and in private practice my cases of lupus heal more rapidly and get permanently cured by this method and in less time than by any other method I have used.

I have ready to report six patients with tuberculous glands of the neck, two already subjected unavailingly to numerous surgical operations for removal who are now perfectly well. One case of tuberculosis of the hip-joint is making excellent improvement.

In tuberculosis of the lungs the method is giving good results, not yet ready to be reported on *in extenso*.

In from one to three days after beginning treatment a reaction occurs. The afternoon temperature in a recent case rose from normal to 103° F. The cough, night sweats, and lassitude increased. Examination of the sputum at this time revealed an enormous increase of the number of tubercle bacilli. This reaction lasted about a week, and then the temperature gradually fell to normal, with corresponding improvement in the other symptoms. The patient then entered on a stage of steady gain in weight and comfort and personal appearance. The case is under most rigid observation by skilled consultants, and will be reported on later.

It should also be mentioned here that not only does the fluorescent method exert a direct remedial and curative action in phthisis, but it also has afforded me, and others to whom I have demonstrated it, a more accurate means of physical diagnosis as to the location and size and extent of pulmonary lesions. When one examines the thorax by the X-ray and the fluoroscope, first without the administration of fluorescin (or other fluorescible solution), and, second, after it has been administered, one is struck by the great difference. With fluorescin, the lesions are more easily distinguishable, they cast a darker and clearer shadow on the fluoroscope, which in its lighter portions is at the same time more brilliantly illuminated. In a word, contrasts are greater and definition clearer.

Among cases in which I have found the method useful are carcinoma and sarcoma, lupus, Hodgkin's disease, tuberculosis, and phthisis, eczema, psoriasis, and also in many nervous affections and insanity.

Summary and Conclusion.

1. The excitation of fluorescence within tissue is a species of phototherapy and dependable on the same basis for curative effects. The term sensitisation is not accurate, for it is not known what the term means. There is no proof that fluorescent substances make the cells or other micro-organisms vulnerable to the exciting radiation.

2. What the fluorescent light lacks in intensity is compensated for by propinquity to tissue.

3. The methods of Tappeiner, 1900, followed by Dreyer, 1903, consists primarily of superficial applications, or of parenchymatous injections submitted to the action of sunlight or to the action of the electric arc light.

4. The method here outlined consists of a medicinal saturation of the entire blood system with a fluorescent solution and submission of parts or of the whole of the patient to the Röntgen and Becquerel radiations and to electric discharges.

5. The method naturally includes filling cavities with fluorescent solutions, as well as using these solutions medicinally.

6. This method is not of the same category as sensibilitisation by Dreyer's method, for the process and the results are different.

7. The curative effects obtained by this method are probably due to the fluorescent light.

8. This method permits of an improvement in skiagraphic effects and of fluoroscopic examinations.

9. Following the suggestions of the use of fluorescent solutions in diagnosis and treatment, the method has proved of value in determining the position and size of the stomach and other cavities of the body.

10. The thoracic cavity presents on the fluoroscope a degree of illumination greater than that produced by the X-radiation alone.

11. The method is useful in tuberculosis of the lungs, and in other cases of tuberculous deposit, as well as in cancer.

Clinical Records.

CANCER HOSPITAL.

A Case of Broad Ligament Cyst. Injury during Enucleation to left Ureter. A Subsequent Laparotomy to Rectify the Ureter.

Under the Care of F. A. Purcell, M.D., M.Ch.

T. C., a monthly nurse, admitted to the Cancer Hospital on February 4th, 1905.

History.—For two months has noticed a lump in the abdomen. Since the summer of last year (1904) has had increased frequency of micturition by day, about every fifteen minutes; this trouble had decreased lately. She suffered from pain in the abdomen during the last three weeks. Bowels constipated. The varicose veins in right leg have been worse lately. Menstruation: For the last two years came on about every three weeks; in November, 1904, had two severe floodings. She is the mother of four children, the last æt. 30. She is æt 53. Looks fairly healthy and well nourished.

Examination.—Abdomen somewhat distended, especially the lower part, chiefly left side. Occupying the lower left side and slightly to the right, extending down into the pelvis, and about two inches above the umbilicus, is a large, rounded, soft fluctuating tumour, movable and slightly tender, dull on percussion. There is a harder portion to be felt on the left side.

Per vaginam.—The anterior vaginal wall is lax and soft. The cervix is perched up against it. Uterus otherwise not made out. The soft mass felt in the left fornix continuous with mass in abdomen. Large varicose veins are present in both legs; on the right side thrombosis about the middle of internal saphena in thigh.

February 8th.—The patient, having been duly prepared for operation, was anæsthetised. The abdomen was opened in the middle line, and a large unilocular left broad ligament cyst was found. Dense adhesions united all around it to the omentum, intestines, bladder, uterus, abdominal wall, and pelvic floor. These were freed and the cyst was tapped, which contained a brownish gelatinous contents, and removed by enucleation. There was a good deal of serous oozing. The cavity was packed with gauze, led through the lower end of the abdominal wall as a drain.

Closing of the Abdomen.—The peritoneum was brought together by a continuous cat-gut suture. The sheaths of the recti-muscles, as also the skin, were brought together by interrupted silkworm gut, each suture passed, after the plan of Mr. Bishop, in the figure of eight method. Ever since Mr. Bishop enunciated his method, I have adopted it with the greatest satisfaction, perfect union with no buried sutures to leave behind resulting. The edges of the recti-sheaths are more closely brought together than if they were brought together in a separate layer. These sutures remain in from ten to twelve days, which gives time for the sheaths to become firmly united.

April 7th.—The drain has been kept in, as a clear fluid (probably urine) escapes. On removing this gauze drain and inserting a female glass catheter, pus welled up from the lower pelvis. A rubber drain was now inserted in the abdominal wound and a self-retaining rubber catheter was left in the bladder.

April 28th.—Average daily urine saved: *Via* abdominal drain, 15 ozs.; *via* urethra, 10 ozs. It was now decided to examine the bladder with the cystoscope, and to explore the ureter through the abdomen. Patient was duly prepared and anæsthetised. The bladder was distended with 12 ozs. of water, the right ureteric orifice normal urine was seen to discharge. The left orifice was seen drawn up into a funnel-shaped process; no urine flowed. The left side of base of bladder adherent. The patient was then raised into the Trendelenburg position. The old scar was removed which showed perfect union. The abdomen was opened in the middle-line. An organised fistulous canal was found to lead down into the left broad ligament and received below into a dense mass of scar tissue. The ureter was with some difficulty exposed above this, and it was found that it had been opened on its anterior wall; it was found impossible to free the ureter from the matted tissue, so it was cut off with the idea of transplanting it into the bladder. This again, was inadvisable, as too much tension would be put on the sutures. The distal end was ligatured. The kidneys were then explored. The "right" was found small and soft, thus rendering the removal of the "left" inadmissible. This accounted for the quantity of urine which was recorded of being 15 ozs by the abdominal drain and only 10 ozs. by the catheter in the bladder, namely, as 3 to 2, being voided. It was then decided to bring the free divided end of the right damaged ureter out through the loin and there sutured; this was duly done. The abdominal wound was closed by the same method (Bishop's) as done before, a gauze drain being lodged down in the left broad ligament space.

July 6th.—The permanent fistula in the left lumbar region is acting well and freely. The abdominal wound is thoroughly healed and sound. Urine voided is in about the same ratio, 3 to 2, by the bladder. Her temperature after first and second operation never rose higher than 101° F.

A glass shield was fitted to the urinary fistula, having a rubber bag with a tap attached, so as to empty the bag. The shield was confined to the waist by an abdominal belt. All urine was satisfactorily caught that was expelled. She put on flesh and feels comfortable in every way. She left hospital on July 6th, 1905.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting held Thursday, December 14th, 1905.

Dr. William Alexander, President, in the Chair.

THE PROPOSED AMALGAMATION OF MEDICAL SOCIETIES.

A special general meeting of the Society was held before the postponed ordinary monthly meeting to consider the question of amalgamation with the other London Medical Societies in order to form a Royal Academy or Society of Medicine as suggested at the General Committee of Representatives of Societies on July 19th, 1905.

The suggested amendments made by the Council of the Society were also considered, and the following resolutions approved and adopted by the meeting:—

The first resolution, was proposed by Dr. Bedford Fenwick and seconded by Dr. Hodgson:—

"That this special meeting of the British Gynæcological Society agrees to the principle of amalgamation with the other London societies, and instructs the Council to take necessary legal steps to safeguard the Fellows of the British Gynæcological Society in the event of the scheme of amalgamation being carried out."

The second resolution, proposed by Dr. J. J. Macan and seconded by Dr. Hugh Woods, was as follows:—

"That in the event of the proposed Union of Societies being carried out, the Council of the British Gynæcological Society have the power to arrange the details of the administration and working of the Section of Obstetrics and Gynæcology in the New Society with the Council of the Obstetrical Society of London, and to co-operate with the latter in the work of forming the Section."

An abstract of the amended report of the Executive Committee of Representatives of London Societies with the suggestions made by the Council of the British Gynæcological Society was presented.

SPECIMENS AND COMMUNICATIONS.

Dr. Richard Smith showed a specimen of associated pyosalpinx and appendicitis, with a concretion in the appendix. The specimen consisted of a pyosalpinx, perforated appendix, and small stone which escaped during the operation. The patient was first seen by Dr. Cross, of Regent's Park. *Symptoms:* Pain in right iliac region increased by movement. Dysmenorrhœa, gradually increasing for five years, and dating from an attack of appendicitis at that time, associated with pregnancy. A hard mass was found in right iliac region, extending half-way to the umbilicus. This mass was tender, and although unattended with rigors or with any pyrexia, did not yield to any medical treatment, and caused most acute pain on the slightest movement. As I had seen her in consultation during her illness five years ago, Dr. Cross kindly called me to join him in the case, and finding that the tumour descended into the pelvis and was in close contiguity to the uterus, we concluded it was probably due to an inflamed appendix adherent to the tube and ovary. Mr. Douglas Drew assisted us in the operation. On opening the abdomen along the outer border of the rectus muscle, we found the omentum adherent. This being released, a dense mass of inflamed hardened tissue was found, in which it seemed almost impossible to differentiate any viscus. Eventually the swollen tube was released without any rupture, but between this and the appendix a small abscess cavity was found containing two or three drachms of pus. The appendix lay deeply embedded at the posterior part of the tumour, and was dissected away from the cæcum. A small perforation was found in it, and a small calculus escaped. No flushing with water was carried out, the pus being removed by means of sterilized gauze. No drainage was adopted. Recovery was quite normal, and the abdominal wound perfectly healed by the tenth day.

In the discussion which followed, Professor J. W. Taylor joined.

Mr. **CHARLES RYALL** said that the case was of interest, for, in spite of the presence of an inflammatory mass and adhesion between the appendix and Fallopian tube as was proved at the operation, yet the pregnant uterus went on enlarging up to full term without lighting up another attack of appendicitis. In his experience, adhesion between the appendix and the female pelvic organs was fairly common, and would be more frequently detected if a routine examination were made at every laparotomy. He had found the appendix adherent to ovary, ovarian cyst, Fallopian tube, pyosalpinx, sigmoid flexure, bladder, normal uterus, myomata, uterus, and even to a carcinomatous uterus.

Dr. C. H. F. **ROUTH** said: A good many years ago, a case was sent to me to the Samaritan Hospital. She was a nurse aged about 42. I found a large swelling about the size of my fist occupying the right groin, and extending to the right side, above Poupard's ligament, very tender, partly solid, and partly fluctuating. Several of the staff met in consultation on the case. She certainly was very ill and feverish. The majority of the staff put it down as a case of strangulated hernia. I could not make up my mind that it was so, because there had been no constipation. However, it was clear it ought to be opened. I did so, and let out a good deal of sinking pus, containing also small pieces of intestine. The relief was instantaneous. The next day, on dressing it, I was surprised to find in the top part of the wound a large piece of intestine, quite as large as my extended hand, in a state of mortification, lying loose on the top of the wound. It was a thick piece, evidently the *cæcum*, and I suppose including the appendix. I dressed subsequently the wound regularly every day. It closed rapidly, and she had no bad symptoms. She was well in three weeks and left none the worse for the operation.

Mr. F. **BOWREMAN JESSETT** said he had seen many cases where the appendix was adherent to various viscera. One point of interest was that flushing had not been used. He preferred to swab out the abdomen and use tube drainage when necessary.

Dr. **RICHARD SMITH**, in reply, said the chief interest was not so much in the adhesions which had formed as in the fact that there was no pyrexia observed at any time. The entire Fallopian tube formed part of the tumour.

COMMUNICATION.

Dr. F. **PURCELL** read notes of a

CASE OF BROAD LIGAMENT CYST OF LEFT SIDE where the ureter was injured during enucleation, necessitating subsequent operation. This case will be found under the heading of "Clinical Records," page 672.

The **PRESIDENT** said there were many points to be discussed, which he would leave to the meeting.

Dr. R. T. **SMITH** asked how the peritoneum was united.

Dr. **DRAPER** wished to know why the ureter was not implanted in the sigmoid flexure.

Dr. **PURCELL**, in reply, said the only method of dealing with the fistula was either to bring out the ureter or remove the kidney; the latter course had not been followed, as the left kidney was small and the amount of urine secreted by it less than from the right. He did not implant the damaged ureter in the sigmoid flexure, as it causes such discomfort. The ureter was embedded in cicatricial tissue and could not be traced, and so was divided above the scar. The operation was successful but for the fistula. The abdominal incision was united by the method described by Bishop in Volume XX. of the Society's *Journal*. He found that method give every satisfaction, and would recommend it to the notice of the Fellows.

HÆMATOMA OF THE OVARY.

Dr. **SAVAGE** then gave an abridged abstract of his paper, commenting upon the most important points for discussion. (This paper appeared in full with illustrations in our issue for December 6th.)

The **PRESIDENT** said most gynæcologists had removed ovaries for pain, and after this paper would be able to understand why some ovaries were painful.

Professor J. W. **TAYLOR** expressed his warm appreciation of the work which had been done in this important field by Dr. Smallwood Savage. It not only advanced our knowledge of a difficult subject, but will lead in the end to some definite classification of the blood cysts of the ovary, and a much better knowledge and appreciation of the factors involved in their causation. He noticed with satisfaction that Dr. Savage did not use the term of lutein cysts in referring to these tumours. It appeared to be just as likely that the blood-cyst, by interfering with the normal process of ovulation, and especially with the retrograding stages of subsidiary follicles, may prevent or retard the absorption or destruction of the lutein layer. In other words, it is difficult or impossible to tell at present whether the abnormal presence of lutein cells in the neighbourhood of a cyst is to be regarded as a cause or a consequence. Is not the one as likely as the other? He necessarily looked at this problem of the blood cysts of the ovary mainly from the standpoint of the clinician and operator. He knew of at least four forms of ovarian hæmatoma which may be related, but are certainly not examples of the same disease: (1) One is specially associated with a twisted pedicle or with the presence of a big myoma, and is caused in both cases, I believe, by pressure on the ovarian veins, partially occluding these and causing big hæmorrhages into the ovary. (2) Another form appeared to be caused by certain blood-vessels which encourage follicular hæmorrhage. (3) A third form is associated with salpingitis, either gonorrhœal or tubercular, and is so far inflammatory in that the inflammation and consequent adhesions round the ovary prevent normal rupture of the follicle. Hæmatoma of the ovary is only rarely a result of this condition, the ovarian swellings usually resulting being of the nature of simple follicular cysts. (4) The fourth form a class (and most, if not all, of Dr. Savage's cases undoubtedly belong to this), he (Dr. Taylor) had recognised for many years as forming a special disease, having characters of its own which demand a fuller investigation, and he hailed Dr. Savage's work as offering a partial explanation, at least, of the problems involved by their presence. The disease generally occurred in strong, well-nourished young or middle-aged women. The patients are mostly single or sterile, or if they have had any children there has been no pregnancy for four or five years. They very often have little or no complaint to make except of dysmenorrhœa, varying in amount until increasing growths on one or both sides of the uterus cause acute pain and demand interference. At operation one finds the uterus and tubes quite healthy, or the uterus may accidentally possess some small fibroid of little or no importance; but one or both—generally both—ovaries are converted into blood-sacs with an irregularly thick and inelastic capsule which is here and there profoundly and peculiarly adherent, and chiefly adherent, I think, where the capsule is thinnest. So that when it comes to removal, they almost always burst at these points, and after removal the cysts do not completely collapse, the thicker parts of the cyst-wall maintaining to some extent their previous shape though the contents are gone. Their "contents" consist of altered blood, generally of a tarry colour and consistence, and if examined bacteriologically, may be perfectly sterile. Such characters have been marked, so far as I remember, in all of my own cases, including the one which appears in the list of Dr. Savage. Regarding this case (No. 7 in his list), I should like to remark that it is the only one which, unfortunately, had a fatal issue, all of his own cases having recovered. The main features, then, of such blood cysts are the absence of any marked signs of inflammation or pain during the early stages of formation—the gradual and progressive enlargement—the peculiar formation and consistency of the cyst wall—the special form and nature of the adhesions; the tendency to burst on manipulation; the tarry contents, and (as Dr. Savage has pointed out) the ill-defined septa found traversing the cyst cavity. The repeated hæmorrhages occurring into one and the same cavity can only be very partially absorbed, and therefore we find a slowly increasing cystic tumour filled with brownish or black and tarry contents, very similar to the contents of retention tumours in atresia. The absorption of the lutein layer which should go on in the substance of the ovary has to take place as best it can in the cortex, and this, the covering of the ovary, becomes irregularly thick, hard, and rigid, while either the tissue changes, taking place in the periphery or an inflammation excited by the morbid ("involution") process, may account for the peculiar and dense but partial adhesions which take place between such an ovary and surrounding organs. The explanation I suggest, as directly built on the facts ascertained by Dr. Savage, and on the facts obtained by operative experience, may not be perfect or contain all the truth; in particular, it offers no solution of the problem as to how the first excessive hæmorrhage arises. It does, however, offer a working theory which may help both to establish the entity of what is, as no one can doubt, a special disease, also to explain some of its phenomena, until a wider investigation may confirm or disprove it.

Professor Taylor showed a specimen of fibroma of uterus with blood cysts of both ovaries, that on the right side being constricted and appearing to consist of two cysts of nearly equal size, the narrow portion was found resting on the pelvic brim, one part being in the cavity of the true pelvis and the other in the abdomen. The left ovary was about four to five times the natural size. The specimen was removed from a young woman who did not know of its existence, but complained of pain.

Dr. H. Hodgson spoke of the close relationship which existed between physiology and pathology. There is physiological waste of every bodily function, and when this waste is excessive pathological conditions follow. He would mention the formation of Pfluger's tubes, and when they were nipped off at the tunica albuginea they developed into Graafian follicles and again came to the surface of the ovary when the ova were extended and cut off. Several similar analogous processes were mentioned. In his opinion a chemical change is one of the factors in causing rupture of follicles, and when this was in excess it might lead to blood cysts. He would have preferred to treat these hæmatomata by glycerine plugs, as he had found them disappear by this means. He did not consider these ovaries required such radical measures as removal.

Mr. F. Bowreman Jessett said that some of the pathological conditions underlying ovarian pain had been explained in the paper. He hoped that it would be possible to differentiate the various forms from the clinical symptoms.

Dr. Savage, in reply, considered the term "inversion process," which Professor Taylor had applied to the pathological condition involved, as being particularly appropriate. In the cases he brought forward, physical signs were undoubtedly present and intimately associated with the pain complained of. Adhesions formed a considerable part of the morbid process existing.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Medicine.

Meeting held Friday, December 8th, 1905.

James Little, M.D., in the Chair.

A CASE OF ACUTE GRAVES' DISEASE ENDING FATALLY.

Dr. J. A. Matson made a communication on the above subject. The following are the particulars:—M. A. H., æt. 20, laundry maid, was sent into the Hardwicke Hospital on April 29th, 1905, suffering from sore throat and difficulty in breathing. Patient on the 19th inst. complained of sore throat, was treated for it, and kept in bed for a few days. She was allowed up, but in a day or so was noticed to be very despondent and melancholic, and her throat again got sore, so she was sent into hospital. *Family history.*—None obtainable. *Previous medical history.*—Had been ten years an inmate of a convent, and was never ill, but was always thought to be delicate. She was always docile in manner. The thyroid enlargement only noticed the day before admission. *Examination.*—Patient is of medium height, thin and anæmic, looking younger than her age. Is heavy and drowsy, though easily roused. Temperature, 99° F.; pulse, 140; respiration, 44. Both the tonsils and pharynx were covered with a viscid creamy secretion, on removal of which the parts were found to be red and inflamed. A swab taken proved negative for diphtheria. The thyroid gland was enlarged, and pressed on the trachea, causing difficulty in breathing; there was slight pulsation, but no bruit. *Lungs.*—Some scattered rhonchi to be heard. *Heart.*—Apex beat 5th space internal to nipple line; 1st sound prolonged over mitral area, no bruit; heart's action forcible and rapid; carotids and abdominal aorta pulsating. *Pulse.*—At the wrist, 144, feeble. *Urine*, 1030, normal. Bowels confined. Amenorrhœa. Eye signs absent. Tremor badly marked. *Progress.*—Severe and uncontrollable vomiting began April 30th, and lasted till May 5th. Her mental condition became worse; she got very restless, wanting to get out of bed, throwing the clothes off; but she would always answer questions, and was very optimistic in her replies. On May 4th, von Graefe's and Stellwag's signs noted. The pulsations in the thyroid also became more marked, and a bruit was heard, systolic in time, over the gland. Her skin became more moist, though there was never any actual sweating, and no pigmentary disturbances. On May 5th the vomiting stopped, and she could retain food by the mouth. Next day she was much weaker, and death ensued on the 7th inst. The temperature ranged from 99° F. to 100° F. on the 5th, rising on the night of May 6th to 103° F., falling to 100° F. next morning, and rising to 101° F. just before death. *Treatment.*—T. strophantus min,v. and T. digitalis min.v. Anti-pyroidin serum hypodermically, ʒii in all, in 10 min, doses; having no effect on pulse it was stopped. Digitalin 1/100 gr., with strychnine 1/60 gr., hypodermically. Ice bag over heart for 15 minutes, only remedy, slowing pulse, which at times reached 170 per minute. Bismuth mixture. Nutrient enemata.

Dr. Finny, in discussing the case, said he found that in ordinary cases of Graves' disease absolute rest, removal of all exciting causes, and electricity gave the best results.

Dr. Moorhead said he was at present observing a similar case, which began three weeks ago with typical diphtheria. The thyroid was not then enlarged, but since then had been increasing in size noticeably from day to day. He stated that he found hypodermics of morphia the most satisfactory treatment.

CARCINOMA CUTIS.

Dr. C. M. **O'Brien** read a paper on the above, with notes of two cases—(*a*) Cancer *en cuirasse*, in a woman, æt. 39. When first seen by him, the growth had involved two square inches of right breast, including the nipple and areola. A month later the skin of upper part of left breast became involved; the growth spread so rapidly that the entire chest became encased within ten weeks of her admission to the Skin Hospital. She died within six months from onset, notwithstanding 10-minute exposures to X-rays were given daily for 13 weeks. (*b*) Paget's disease of nipple, in a man, æt. 53. The right nipple and areola were infiltrated, the former slightly retracted, the limitation of patch, and its red, raw, granulating appearance were very characteristic; for a period of nearly three years it had failed to yield to almost every well-known remedy for eczema.

Dr. W. G. **Smith** referred to the rarity of Paget's disease in a man. He discussed the diagnosis, laying stress on the extremely sharp limitation of the disease and the leathery induration of the skin.

Dr. **Winter** spoke of a case where a patient had improved on treatment with X-rays, but going away before a cure had been effected, returned, and was treated with radium; though again going away before completion of treatment the case had gone on improving, and no return had occurred since—an interval of twelve months.

UNUSUAL CASE OF SUDDEN HEMIPLEGIA IN A CHILD.

Dr. **Travers Smith** recorded the case of a little girl, æt. 7, who was admitted under his care to the Whitworth Hospital, her mother having noticed the same morning that the child was unable to dress herself, owing to loss of power in her right arm and leg. The day previous to admission the child had been apparently quite healthy—in fact, had never been ill except once from acute bronchitis. On admission the child was found bright and intelligent; temperature, 100·8° F.; pulse, 110; respiration, 26. The right arm and leg showed complete paralysis, were absolutely flaccid, and exhibited no tendon or cutaneous reflex action. Babinski's sign was absent. The right side of the tongue and lower half of face on the same side were also paralysed. No aphasia was present. Sensation was normal. The child remained in exactly the same condition for a week, then became dull and stupid; the temperature went a few degrees higher, whilst the pulse became slower. By the end of the second week she had become comatose, her pupils were dilated and irresponsive to light, she was unable to swallow, her sphincters relaxed, the temperature fell to subnormal, the pulse became very slow, the respiration irregular. These symptoms being recognised as those of intra-cerebral distension, lumbar puncture was performed. (Dr. Travers Smith expressed the view that in no case should cerebral ventricular distension be allowed to constitute the immediate cause of death, any more than distended pleural cavities should be allowed to do so without being relieved. There was always the hope in obscure cerebral cases that the primary cause of the distension might be something transient, and not necessarily fatal—*e.g.*, cerebro-spinal meningitis.) The cerebro-spinal fluid in this case flowed freely, the flow being increased by pressure on the head. The fluid was perfectly clear, no organisms could be cultivated from it, and it was too poor in cells of any description to draw diagnostic deductions from its cytology. Temporary improvement followed the lumbar puncture but coma deepened again; internal strabismus of the right eye, and intermittent spasm of the eyelid developed. The child died two days later, on the 18th day of her illness. *Post-mortem.*—The dura over left Rolandic area was found thickened and adherent to the cortex owing to old tubercular inflammation. About the middle of this adhesion a small cortico-meningeal abscess, the size of a pea, was found. The base of the brain showed miliary tubercles along the vessels, but only moderate inflammation. The cerebral ventricles were moderately distended. The cord showed no signs of meningitis, and microscopic sections were normal. The brain and cord were otherwise healthy. Dr. Travers Smith considered the points of chief interest in the case were—(*a*) the sudden onset of the hemiplegia, which he attributed to sudden vascular congestion of the old tubercular focus; (*b*) tne total loss of reflexes and flaccidity of the paralysed limbs, even when there were as yet no signs of the terminal tubercular meningitis; (*c*) that such localised tubercular foci may explain the obscure occurrence of hemiplegia during childhood in other cases; (*d*) the involvement of the face and tongue is rare in the hemiplegias of childhood. Dr Earl kindly examined the spinal fluid and cut sections of the spinal cord.

Drs. Kirkpatrick, Langford Symes, and Bewley, in discussing the case, all spoke of the peculiar condition of the limbs. Dr. Bewley also asked whether it were possible that an embolus had lodged in the middle cerebral artery?

Dr. **Travers Smith** said there was no embolus, and referred to the absence of reflexes commonly met with in general meningitis as an explanation of the condition of the limbs.

STOKES-ADAMS SYNDZOME.

Dr. **Parsons** read a paper on the above subject. Having referred to the original cases recorded by Stokes and Adams, and to Osler's and Hay's more recent observations on this symptom group, he read the notes of a case which was recently under his care at the Royal City of Dublin Hospital. The patient was 68 years of age, and a gardener by occupation. He enjoyed excellent health till last May, when he suddenly became unconscious. From May to October he had from 7 to 10 attacks of unconsciousness, lasting from a few minutes to four hours, and not accompanied by any convulsive movement, or followed by any paralysis. The patient's pulse generally ranged from 30 to 40 per minute, and there was advanced arteriosclerosis. Tracings from the heart and radial artery were exhibited, and it was suggested that a possible explanation of the bradycardia was a partial heart block owing to degenerative changes in the tissues in the neighbourhood of the auriculo-ventricular groove.

Dr. **Finny** gave an account of a case very like this, occurring in a woman.

Drs. Travers Smith, Drury, and Watson also spoke.

Dr. **Kennedy** showed a case of tumour of the brain.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held at Manchester, December 15th, 1905.

Dr. **Lloyd Roberts**, President, in the Chair.

Dr. W. **Walter** showed a "Fibromyoma of the Uterus," removed by supra-vaginal hysterectomy from a patient, æt. 60. The chief interest of the case was due to the fact that the tumour was rapidly increasing in size, although the patient had passed the menopause twenty years previously.

Mr. A. J. **Radocanachi** showed the external genitals removed on account of their precancerous condition. Sections of the skin showed the appearances characteristic of kraurosis, while inflammatory infiltration caused considerable tumefaction of the subcutaneous tissue.

Drs. W. K. **Walls** and H. **Clifford** showed uterine dilators graduated according to the English catheter gauge, and so constructed that the tip of each had the same measurement as the next at a point one inch from the tip.

Dr. W. E. **Fothergill** showed four "Myomatous Uteri" which had been impacted in the pelvis and had been removed by supra-vaginal hysterectomy on account of pressure symptoms. One uterus was pregnant at the time of operation, and another was removed one week after the patient had been delivered by pushing up a portion of the growth and turning.

The **President** recommended the use of catgut ligatures in vaginal hysterectomy, and showed carcinomatous uterus from a case in which the broad ligaments were secured in the vaginal vault by the sutures closing the vaginal wound. All the catgut ligatures were cut short, no sloughing occurred, and healing took place in a week by first intention, the only treatment being two packings and a little vaginal douching.

The **President** also showed a fibroma of the cervix enucleated through a vaginal incision, and urged the claims of enucleation as the ideal treatment for uterine fibroids before the menopause. Small fibroids left in the uterus were no bar to future pregnancy, and they frequently shared in the involution of the organ after parturition, thereafter giving no further trouble.

Dr. **W. K. Walls** described a case of rupture of the uterus in which abdominal hysterectomy was followed by recovery.

PARA-VAGINAL SECTION.

In a paper on this subject, Sir **W. J. Sinclair** regretted that this operation advocated by Schuchardt in 1901 was not now employed so often as it might be with advantage. It was the best operation that could be chosen in one class of cases, and the only operation that could suitably be done in another. In cancer of the uterus, advanced but not inoperable, it was the operation of choice, for it raised the percentage of operable cases and gave better remote results than vaginal hysterectomy without exposing the patient to increased risk. It had great advantages over abdominal hysterectomy with pelvic dissection, which had a very high mortality without a proportionate improvement in the remote results. Para-vaginal section was thus the best operation in advanced uterine cancer, but further it was the only operation at all suitable for certain cases of another kind. Of these, four examples were given. Two were cases of atresia uteri with hæmatometra and hæmatosalpinx which caused excessive pain and endangered life. Both ovaries had been removed in one and one in the other case by other operators. In a third case a senile virgin, æt. 55, had a sloughing intra-uterine growth, while the fourth patient was æt. 40, and had a narrow vagina and a fibrous uterus which had caused excessive bleeding. In these four cases the affected organs had been safely and simply removed by the help of the para-vaginal incision. Without this aid, the narrowness of the vagina in each case would have necessitated an abdominal operation which would have exposed the patient to risks much greater than those attending the para-vaginal operation.

ULSTER MEDICAL SOCIETY.

Meeting held in the Medical Institute, Belfast,
December 14th, 1905.

The President, Dr. **William Calwell**, in the Chair.

Dr. **Calwell** said that since the last meeting death had been busy in the ranks of the profession connected with Ulster. Dr. J. F. Stewart, the only son of Dr. James Stewart, of Belfast, was qualified in 1898, and after serving in the Boer War had entered the Colonial Service on the West Coast of Africa, whence news has just arrived that he has been murdered by natives. Dr. James Waddell, another Belfast man, was qualified in 1900, and entered the Royal Army Medical Corps. He has died in South Africa. Dr. James Lynass (to whose tragically sudden death reference was made in these columns on the 13th inst., was a Fellow of the Society, and his death leaves a sense of loss with all the members of it. Appropriate resolutions of sympathy were passed to the relatives of these gentlemen.

Dr. **John McCaw** read notes of an interesting case of

ANÆMIA IN A CHILD.

The patient was admitted to the Belfast Hospital for Sick Children under Dr. McCaw's care with what looked at first like acute lymphatic leukæmia. But he had a hard swelling in each temporal fossa, and his eyelids were black with ecchymosis, and his eyes proptosed. A periosteal swelling on the lower end of the femur suggested scurvy, but the history and course negatived this view. He died on the twenty-first day after the onset. The blood was examined by Dr. Beatty, who found that it conformed to the type of pernicious anæmia, and Dr. McCaw believed that the case was one of those described by von Leube as leukauæmia. Dr. Houston, who had seen the blood films, agreed that it was like a pernicious anæmia, and Drs. McQuitty and McKisack thought that it might be a case of chloroma, the swellings in the temporal fossæ being characteristic.

Dr. **McCaw** also read notes of a case of Chorea treated with salicylate of soda, and showed a case of Pseudo-hypertrophic Paralysis.

Dr. **Percy Crymble** showed a case of "Locomotor Ataxia Treated by Fraenkel's Method," and demonstrated the method. The patient had been under treatment since November 5th, on which date he could not walk or stand with his heels together. Now he could walk very fairly, and perform the various exercises which constitute this interesting and seemingly most useful method of treatment.

Dr. **J. C. Rankin** showed several patients treated by the Finsen Light.

Dr. **William M'Harry** showed a New Truss, made to his design, the point of which was the pad was arranged on a sort of ball and socket point, so that it could be moved about to find the best position when on the patient, and then clamped in that position.

Mr. **A. B. Mitchell** congratulated Dr. M'Harry on his invention, expressing himself as greatly pleased with the idea, and anxious to try it in practice.

Dr. **M'Harry** also showed a gynæcological crutch for use by general practitioners, so made as to be fixed in a moment at the end of an ordinary couch, and moved out of the way when not wanted.

Dr. **McKisack** showed two cases of "Tuberculous Peritonitis," treated by Wright's method of giving tuberculin. The patients, æt. 14 and 17, were both well-marked cases; they began to improve immediately treatment was begun, and now, after three or four months' treatment were apparently in perfect health, no lesion being detected. The obsonic index of the blood had risen from considerably below 1 to above normal.

Dr. **Thomas Houston** read a note on a new method of "Testing the Efficiency of the Kidney," as described by Professor Wright.

Mr. **Andrew Fullerton** showed (*a*) photographs of a case of deformity of the nose treated by injection of paraffin; (*b*) the urine segregators of De Luys and Harris, and discussed their use, reading short notes of several cases; (*c*) three cases of Congenital Dislocation of the Hip, the notes on which we hope to publish in our next issue.

The following were elected Fellows of the Society:—T. M. Tate, B.A., M.D., and W. P. Tate, M.B.; and Mrs. Annie K. Watson, M.B., was elected a Member.

France.

[From our own Correspondent.]

Paris, December 26th, 1905.

Compulsory Notification in France.

Many years after the notification of infectious diseases was made compulsory in this country, it occurred to the French Government to introduce similar legislation. It is hardly necessary to say that the project met with great opposition. In the first place, it was in flagrant opposition with the policy of secrecy which appeals so cogently to administrative officials over here, and secondly it seemed to infringe the ethical principle of professional secrecy on which men are intractable. The law was passed, nevertheless, and matters remained pretty much as they were before.

A young French medical man mentioned to us the other day that when he set up in practice, anxious to comply with all established laws and customs, he asked one of his senior *confreres* whether he ought to consider himself under an obligation to notify any cases of infectious disease that should come under his notice, and he was advised that although it was the law it was more honoured in the breach than in the observance. The result is that epidemics almost invariably obtain a firm hold before the sanitary authority, such as it is, receives any intimation thereof. The difficulty in enforcing the law appears to be for the present insurmountable, for it can only be enforced by the local authority, *e.g.*, the Mayor of the Commune, and he in most instances is unwilling for municipo-political reasons to incur the unpopularity that its rigid enforcement would inevitably entail.

Then, too, if he attempted to constrain a medical man to carry out the law he would at once put the whole fraternity in arms against him, hence a deadlock. Fortunately the opposition ceases when confronted with virulent diseases such as bubonic plague and cholera, but in such cases the difficulty of diagnosis leads to delay.

Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, December 24th, 1905.

At the Medizinische Gesellschaft, December 6th, Hr. Rothmann discussed the

Conduction of Sensibility in the Spinal Cord.

After a short historical notice he passed in review the tracts concerned in the conduct of sensibility; these were the posterior columns, which represented the shortest and most direct route, the cerebellar lateral tracts, and with them a number of shorter fibre tracts. But it was not all these tracts that conducted sensibility, and by this the question became more complicated, or was still further complicated, by the sub-consciousness by means of which common sensation reached the deeper parts of the brain.

At first same-sided conduction in the cord was assumed for sensory impressions, later on a bilateral, until still later Brown-Séquard assumed that all sensory nerves crossed, and upon this the classical Brown-Séquard paralysis was founded. But long ago Schiff was of opinion that only the main body of sensory fibres crossed, and that under certain circumstances a considerable minority of them did not. This had been confirmed experimentally. Then the view was that the greater part of the nerves conducting pain and temperature, passed through the lateral tracts of the cerebellum to the brain, but this was not tenable, otherwise there would be no perception of pain and temperature after removal of the cerebellum, and this was not so. Ziehen had shown that a number of shorter lateral tracts were of great importance as regarded these sensations.

The speaker had divided the anterior column transversely just below the pyramidal decussation in some apes and dogs, and had thereby set up disturbances of the sense of touch and mild atactic symptoms. He had also severed the lateral and posterior column separately and in different combinations.

In the sense of touch the anterior and posterior columns were the chief channels; after severing them pain was still felt, but not temperatures. The chief sensation; of pain in the dog were conducted by the lateral columns. If these were divided, however, coarse sensations would still pass; a portion of the sensations must therefore run in the short tracts. Sensation of pressure passed along the same tracts. muscular sense in all three long tracts.

The conditions in man were but little known, as pathological conditions were almost always complicated, whether in tabes, tumours, or other diseases. Punctured wounds of the cord had, however, the value of an experiment. Mostly a Brown-Séquard paralysis developed as a result of a wound. More careful investigation showed that pain and temperature sense were quite extinguished; the decussation here appeared, therefore, to be complete. Further observation showed that if the patient survived, a wide restitution took place even when a half of the cord was divided. This could only be explained by the uncrossed fibres taking the place of the divided crossed ones. Sense of pain and heat were only abolished when both sides of the cord were divided. Sense of pressure appeared to be conducted along the same routes as the others; for the sense of touch the anterior and posterior columns appeared to be employed. Observation certainly taught one thing, and that was that each kind of sensation had more than one route to follow. This opened up the possibility of proceeding with more daring in the surgery of the cord, without fear of permanent disturbances of sensibility. What tracts there were in the individual cases, and what their limits were, was the province of experimental inquiry to work out.

Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, December 24th, 1905.

Traumatic Porencephalic.

Ranzi showed the members of the Gesellschaft a preparation taken from a labourer, æt. 20, who met with an accident six years ago that left an opening in the cranium and brain substance in the posterior part of the temporal region. This bony orifice was about the size of a two-shilling piece, becoming less as the tunnel approached the ear. Within this orifice the pulsation of the cerebral vessels could be distinctly seen.

With the object of closing the defect a horse-shoe incision was made round the opening, and the bony surface laid bare. The fibrous membrane filling the opening was then split, revealing a large cavity that would contain a hen's egg, from which a large quantity of serous fluid discharged. After carefully drying the cavity, it was found that the opening communicated with the right lateral ventricle on the floor of which could be seen the hypocampus and choroid plexus. The cavity was then filled with Viaform gauze, a drainage tube, and the cuticular surface of the wound closed.

The following day all the symptoms of meningitis appeared; temperature 39° and pulse 130 to 150 per minute, with the neck perfectly fixed and stiff. The dressing was changed twice a day. On the second day all the symptoms of danger disappeared, but on the sixth day after the operation the patient died.

The *post mortem* showed that no trace of meningitis was to be found. The whole of the post-operative phenomena appear to have been produced by the cerebral œdema which was present, thus increasing the vascular pressure. There was also evidence of a slight form of chronic hydrocephalus with closure of the foramen of Mayendie.

Lupus Carcinoma.

Riehl showed a female patient, æt. 41, who had suffered from her sixth year from lupus vulgaris on the face, which began first on the left cheek, and gradually extended over the whole. Five years ago a papular, warty condition commenced in the left cheek, which, three years later, were removed. After the excision a soft scar formed over the site, followed by the growth of a few other nodules in neighbourhood, with horny disquamation. These, when carefully examined, turned out to be tumours of epithelial carcinoma arising on the base of a lupus or lupus scar.

The Operating Theatres.

ROYAL FREE HOSPITAL.

Radical Cure of Inguinal Hernia in Children.—Mr. Willmott Evans operated on a boy, æt. 3½, who had been admitted for the radical cure. The child having been anæsthetised with chloroform, an incision was made about one and a quarter inch in length over the external ring, which was exposed, and the cord laid bare. In the interior of the cord, the processus vaginalis was found passing down to the testis. The processus was carefully and clearly separated from the surrounding structures and was ligatured immediately above the testis and divided a short distance above the ligature. The upper part was then traced upwards as far as possible and separated, and the processus was again ligatured as high as the internal ring, divided a slight distance below the ligature, and the remainder removed. Three skin stitches were inserted and gauze and collodion dressing put on, and when this was dry a pad of gauze and a bandage applied. Mr. Evans said that the hernia in this child was noticed within a few weeks of birth and it was undoubtedly an ordinary congenital inguinal hernia, the herniated bowel passing along the unobliterated processus vaginalis. The attempt had been made to induce the processus to close by the wearing of a truss, and this had been continued until the child was nearly three years of age, when the mother had discarded the truss as useless. The case was first seen by Mr. Evans about three weeks before operation; it was recognised that any truss treatment could now have no reasonable chance of causing obliteration of the processus vaginalis, and he had therefore operated. The general question of treatment of the congenital variety of inguinal hernia in childhood was, he considered, one of considerable interest, not only from the frequency of its occurrence, but also from the importance to the patient during the rest of life, for a child with a hernia was undoubtedly heavily handicapped, as the rupture was always in danger of strangulation, also because the little patient was prevented from indulging in many sports and afterwards was unable, when older, to obtain admission to any of the Services, and some other forms of employment. In children, during the first few months of life, there was, he said, a natural tendency towards closure of the processus, in fact, the non-closure might be looked upon as merely delay in the carrying out of the natural process, but in order that this natural closure should occur it was absolutely essential to prevent the descent of the intestine. If the walls of the processus were kept in contact at this early age for a few weeks or months, the chances of union were very great, but if, on merely a single occasion, the intestine were to descend all the benefit of months of the employment of a truss would be completely lost. In this early stage, therefore, the employment of a truss was all that was needed, but the truss must be kept applied continuously, even during sleep and in the bath; if this were done, it was probable that a cure would result in over 90 per cent. of the cases, but a temporary neglect of the precautions would be likely to be followed by utter failure. It was obvious, he pointed out, before the employment of trusses that any causes of increased abdominal pressure must be removed; any bronchitis must be cured, constipation must be treated, and should phimosis be present, circumcision should be done. This expectation of a natural cure of the congenital inguinal hernia must not extend beyond the end of the first, or at latest the end of the second year; should the child have arrived at the age of two years and still suffer from a congenital inguinal hernia, it was, he thought, of little use to employ the truss treatment with the hope of a cure; of course, a truss would be useful in preventing strangulation, but it will rarely have any curative effect. Therefore, after the age of two or two and a half years recourse should be had to operation, the time being chosen when the child's health is otherwise good, especially when there is an absence of bronchitis, and on the whole he thought it better to choose spring and autumn rather than the summer or winter for these operations, as a child is less likely to be upset by extremes of heat or cold in the former. The elaborate operations which have been devised for radical cure of inguinal hernia in adults are, fortunately, he stated, not in the least required in radical cure of the congenital variety of inguinal hernia in childhood, in these cases there has occurred no displacement of the relative positions of the inguinal rings; the inguinal canal is still existent and perfect, and therefore needs not to be re-made. The only structure which requires treatment is the patent processus vaginalis, therefore this is removed after having been ligatured immediately above the testis so as to form a tunica vaginalis for the testis, and as high up as possible, practically at the internal ring. No attempt is made in the average case, he said, to narrow any part of the inguinal canal, the external ring itself is very rarely found to be larger than normal, and therefore needs no treatment, so that the whole operation consists merely in the skin incision, the ligature and removal of a portion of the processus vaginalis, and the suturing of the skin wound. Mr. Evans considered it advisable to seal the wound with gauze and collodion as there was some risk of it being soiled with urine. As to the results, they were, he pointed out, all that could be desired if due care were taken to ensure the asepsis of the wound. Recurrence was unknown. He did not wish it to be thought, however, that he meant to imply that there were no cases of inguinal hernia in children requiring a more elaborate procedure, for occasionally cases might be found even in childhood where the abdominal wall was exceedingly weak, but such cases were exceptionally rare, and could not be held to modify the general rule that the radical cure of congenital inguinal hernia in the child was an extremely simple operation. The question naturally arises, he pointed out, whether it is desirable for the patient to wear any truss after operation; he did not think it necessary, but he was in the habit of advising the use for a few months of a light linen support, exerting slight pressure over the inguinal canal.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 27, 1905.

PATHOLOGICAL EVIDENCE AT INQUESTS.

The recently-founded medico-legal society is doing excellent work in bringing lawyers and doctors into personal and friendly relations with one another; such an institution has long been needed. The asperities that so often mar the contact of law and medicine arise from misunderstandings of each other's aims quite as much as from divergence of ideals, and open debate is the best solvent for present discontents in these matters. When lawyers understand a little of the scope and methods of medical science, and doctors a little of the scope and methods of the law it becomes apparent to each that in spite of appearances both professions are not only needful to society but even beneficent in their operation and complementary to each other. There is, in fact, no reason why lawyers and doctors may not be the best of friends, and the interest taken by leaders of both professions in the Medico-Legal Society, as evidenced by their presence at its meetings, augurs well for a better understanding in the future. At the last meeting the important and topical question of the function of the expert pathologist at inquests was under discussion, the debate being opened by a lucid and vigorous paper from Dr. F. J. Smith. We may take it that this paper was designed rather to instruct the lawyers than to enlighten the medical members, for the burden of Dr. Smith's contention was that it is by no means always possible for even the most skilled and experienced pathologist to discover the cause of an individual's death by making a *post-mortem*, and therefore that evidence founded purely on pathological evidence is necessarily incomplete and open to fallacies. This proposition would naturally be conceded at once by any competent medical man, but it is well that the legal members of the Society should realise its truth and its significance. A further point—which again would be heartily endorsed by any doctor—was made; namely, that though in a given body certain pathological lesions may be found, even lesions of considerable magnitude, it may no means necessarily follow that death has resulted from them. The fact of man's having calcareous aortic valves or a contracted kidney does not negative the possibility of his having died by poison, and it is notorious that many poisons—such as the vegetable alkaloids, for example—leave no signs in the tissues such as would make a pathologist suspect their having been administered, unless his suspicions were already aroused. Deaths from many diseases, moreover, leave no pathological evidence of their presence, or such evidence as is ascertainable by autopsy may, and frequently is, wholly insufficient to account for death. That many fatal conditions leave no indelible mark of their occurrence is far from being an exceptional experience; indeed it is a commonplace of medical knowledge that such is frequently the case. Dr. Smith cited the records of the London Hospital for nineteen months to illustrate this point. During that period 2,123 *post-mortems* were performed, and in 102, say five per cent., there were no naked eye changes to which death could be ascribed. Now in a general metropolitan hospital a large number of cases of diseases that leave little evidence of this presence, particularly of course the acute zymotics, are not admissible, and it is safe to assume that in routine practice a far larger proportion even than five cent. of negative findings would be encountered. Again, too, even if gross disease is discovered *post-mortem*, it is seldom possible to assert with complete confidence that that disease must inevitably have been the proximal cause of death; the best that can be said in the absence of clinical knowledge—is that such and such disease existed, and was sufficient to cause death. Dr. Smith ran through some of the fallacies attending the making of autopsies which may deceive the most experienced, and showed how even the aid of prolonged microscopical examination is frequently insufficient to fix the responsibility for death on any particular lesion. The argument, then, for associating pathological evidence with the clinical history before making a diagnosis of the cause of death is irresistible to instructed minds, and Dr. Smith put it none too strongly when he said that "that procedure of a coroner's court by which a verdict is arrived at on the evidence of the pathologist alone is a farce, for no such person, even if skilled, can by naked eye evidence alone determine the true cause of death in a completely satisfactory manner." Dr. Smith was no less sparing of the "self-assertive, would-be experts," who distort the accidental exudations and congestions which take place after death into evidence of genuine pathological appearances. Sufficient to account for death, though he admitted this class of error was of infinitely less importance than that of attributing, on pathological findings, a death from morphia poisoning to bronchitis. It cannot but be exceedingly gratifying that these facts which after all are not capable of being seriously disputed, should be placed before legal minds by a physician of Dr. Smith's experience and standing, so that they may be in a position to understand some of the reasons why the medical profession, as a profession, object to the procedure sometimes adopted in South West London. Dr. Smith, nor any other reasonable man objects to the assistance of a really skilled pathologist supplementing the pathological investigation of a general practitioner in cases of difficulty; indeed, the help of a respected colleague under such circumstances is gladly welcomed. But to disregard the clinical history of a patient is to neglect a link in the chain of evidence quite as, if not more, important than the *post-mortem* findings, and as each is complementary to the other, neither can be omitted in any case of doubt or difficulty. The ascertainment of truth is not so easy that the chief clues can be neglected.

THE SKELETON OF CHRISTMASTIDE.

CHRISTMASTIDE is a season wherein one wishes to rejoice, as it were, of set purpose, and to dwell as little as possible for the time being upon the deeper issues of life. Hence mankind is, for the most part, content to take things as they are, or as they seem to be, without further parley. For those who are affluent, Christmas brings a surfeit of good fare. The butchers' shops become monotonous with their hecatombs of edible domestic animals of all sorts—drawn, quartered, and displayed with an eye to effect. It may be fairly assumed that not one man in ten thousand who gazes on the Christmas show of meat in the butchers' shops bestows a moment's thought upon the magnitude of the slaughter that it connotes among highly organised mammalia. Death has often been inflicted, moreover, under circumstances of appalling and atrocious cruelty. Indeed, a contemplation and analysis of the meat trade at any time is enough to make any tender-hearted citizen become a vegetarian for the rest of his days. If we turn to the poulterers', much the same sort of thing may be seen. Geese and turkeys, pheasants, hares, wild-fowl, and game of all kinds are killed in innumerable scores of thousands for the Christmas market. Man's merriment in this instance is inseparably connected by long tradition with an enormously devastating sacrifice of life among the lower animals. While the fact may be lamentable, it must be accepted as one of the laws of life that renders the self-preservation of individuals dependant upon the consumption of other forms of animal life, almost universal. The world is one huge battlefield, and among this world-strife there is no species more predatory and more cunning and successful in his destructiveness than man, who by reason of his intellectual development stands at the head of the mammalia. From the wreckage of various creeds he has evolved certain feast days, of which Christmas still retains the traditions of abundant food festivities. Just at this season comes the announcement of the foundation of a new Anti-vivisection Society. Rejecting the milder methods of existing societies, which seek for the control and regulation of scientific vivisection, they will rest content with nothing short of absolute suppression of this thing that is the red rag of their petulant hobby. How many of these anti-vivisectionists, whose mental attitude commands our sympathy although not our respect, have ever paused to consider the inwardness of the Christmastide slaughter? Have they ever looked analytically upon this picture of the butchers' and the poulterers' shops on the one hand and upon that picture of the scientific laboratories on the other? Here we see a vast sacrifice of life, representing a vast amount of cruelty, with the sole purpose of providing folk with extra food for their Christmas enjoyment. There we see carefully planned research carried out under the most humane conditions known to science, with one single end and aim, namely, the preservation of human life from suffering and from death. The great fundamental distinction between the two sacrifices of the life of the lower animals in the two instances under consideration is that one is intended merely to satisfy the greedy maw of jovial man, while the other is intended to save him from bodily ills of all kinds. How can a sane, intelligence condone the butcher and condemn the vivisectionist? If anyone said of the butcher what is said every day in the week about the vivisectionist, the anti-vivisectionist would retort that the objections were sentiment gone mad. Yet all the while he swallows the camel of animal food but strains with restless and incessant bitterness against the gnat of vivisection. The life of the lower animals is subservient to him for food, for labour, for clothing, for ornament, for anything and everything in his narrow world, in short, save for the one high purpose of acquiring the knowledge of preserving the health and the lives of his fellow men. As men grow more intellectual and reasoned in their outlook, so will they be likely to regard the question of vivisection in its true perspective. With that comfortable conviction we take leave of the subject and embrace the opportunity of wishing our readers, even if they be anti-vivisectionists, every good wish that pertains to the present season of Peace and Goodwill upon earth.

Notes on Current Topics.

Insurance Without Medical Examination.

Life insurance companies that offer to accept candidates without medical examination are offering a shadow without a substance. For the skilled medical examiner is substituted a host of detailed questions, and the history of every previous ailment is rigorously investigated and previous medical attendants consulted. This secret or demi-semi-secret investigation is all the more rigorous inasmuch as it has to be conducted by a band of amateur medical detectives in the shape of insurance office clerks, agents and other officials. The chances are tolerably certain that no man with any marked illness or failure in health will pass that ordeal. As a matter of fact, the amateurs have to protect themselves by frequent and continuous high rating of the lives of applicants who are lured to their office, forsooth, by the bait of escaping a medical examination. There are many grave maladies, however, such as locomotor ataxy, exophthalmic goitre, and latent heart disease, which can be detected only by the highest medical skill. Happy the insurance company, therefore, that leaves to qualified medical men the determination of the state of health of applicants. Thrice happy, moreover, is the company that has not to resort to such catchpenny unworthiness in order to attract customers.

The Hospital Sunday Fund Voters.

The question as to the legal constitution of a vote at the Hospital Sunday Fund meetings was raised last week in the public press. A gentleman, well known as a noted writer, went to the London Mansion House with a view of attending the annual meeting, but somehow strayed into the council-room, where he heard a busy discussion going on as to what resolutions and amendments should be permitted. As these matters are usually settled by the votes of a meeting, and not by the chair, and as, moreover, the unintentional intruder was bent upon seconding an adverse motion, his attention was naturally turned to an analysis of his somewhat humorous situation. As a matter of fact he was there to support the Hon. Stephen Coleridge in his attempt to separate hospital from medical school funds. Though we have little sympathy with the methods of that gentleman, he is, nevertheless, entitled to be treated with absolute justice. Either there is or there is not a legal vote at the meetings of the Hospital Sunday Fund. Mr. Coleridge's contention is that few of those present possessed the proper legal qualification, but that anyone who chose to attend was permitted to vote. He challenged a scrutiny, as he was perfectly entitled to do, but that demand was refused by the Lord Mayor. We can only say that if the meeting was packed with those voters who were allowed to vote, the proceeding, if not permitting a scrutiny, was high-handed and absolutely unjustifiable. What have the Sunday Fund to say? *Fiat justitia, ruat cœlum.*

The London School of Clinical Medicine.

THE "Dreadnought" Hospital at Greenwich is about to make a departure of considerable importance in medical education. Hitherto it has been known as a large and flourishing institution, famous for having founded the London School of Tropical Medicine. Early in the coming year, however, it will embark on a far wider field of work, namely, the formation of a school of clinical medicine. A comprehensive course of post-graduate teaching in every branch of medical knowledge will be organised under some of the best teachers London can produce. The scheme of education for the medical man who wishes to revise and bring his knowledge up to date, is more comprehensive than that which exists at the West London and the Tottenham Hospitals. It will be of the greatest value to Army and Navy surgeons home on "study leave," especially as the "Dreadnought" Hospital receives a great number of seamen from all parts of the world, and thus offers a fine field for the study of tropical diseases. Already certain hospitals have affiliated themselves to the London School of Clinical Medicine. They are the Waterloo Hospital for Children and Women, the Bethlem and the General Lying-in Hospital. This enterprise deserves well of the public, inasmuch as it is likely to prove a great corner-stone in medical education, and one that has become absolutely indispensable in these days of rapid progress in every branch of medical and surgical science.

Politics and Public Health.

CHANGES of Government fortunately do not entail a complete bouleversement of Government offices, for the executive of each department remains unchanged however often its political heads may come and go. Indeed, it is difficult to imagine how any business could be carried on if the whole staff of the Government departments were to be changed with each successive Ministry. In America things are different and even in municipal affairs the executive officers not only may be, but frequently are, turned out as each party comes into power, so that their places may be filled with political supporters and friends. A rumour is abroad in New York that the new Mayor, Mr. McClellan, is about to dismiss, or rather not to reappoint, Dr. Darlington the Health Commissioner for the city, and our contemporary the *Medical Record* speaks out strongly on the subject. It admits candidly that Dr. Darlington's appointment two years ago was a bad one; he was put in in place of an experienced officer when he himself was quite untrained in sanitary science. Now, however, after two years' experience, he is beginning to be of some use, but with a new Mayor the chances are that some fresh tyro who has been of service in the political world will be jobbed in. "The system," says our contemporary, "is rotten," and so should we say too. No wonder that "grafts" are sought everywhere, and that men try to make what they can when in office. We should have thought the health of New York too serious a matter to be thus trifled with.

Municipal Doctors.

EVERYONE is agreed that the rates for infantile mortality in the United Kingdom are a standing reproach to our sanitary methods of life. It is for instance, not a little disconcerting to see that while in England the death-rate for the last ten years has been 153 per 1,000 births and in Scotland 127 per 1,000, in Stockholm it is 100, and in Buenos Ayres, which is far from being a healthy spot, only 91. Mr. Anderson, the convenor of the Glasgow Health Committee, and Alderman Broadbent of Huddersfield, are anxious to have a national conference on the subject with a view to saving the lives of some of these infants that perish so unnecessarily, but in the meantime Mr. Anderson has piloted through his Council a motion that may have far-reaching results in another direction The proposal he makes is that in addition to the lady health visitors with which the Corporation is provided, a lady doctor should be appointed who should go on the summons of a health visitor to attend children who are ill in the City. We hope that the Corporation, whom we willingly recognise are actuated by none but the highest motives, in approving of this arrangement, will exercise great care as to the limitations they set to this lady's sphere of action. Medical practice is a delicate thing to meddle with, and already encroachments of various insidious varieties have set in and begun to operate unfairly to those doctors who practise among the poor. It has always been found that arrangements can be made whereby the thrifty poor can obtain medical attendance at a fee within their means, and if another doctor be added to the municipal staff, especially for the purpose of practice in the homes of the people, it may easily happen that abuses will arise which it will prove a difficult matter to curtail.

A Check to Anti-Vivisectionists.

Since Mr. Chamberlain sent a very curt reply to the Birmingham anti-vivisectionists who desired his influence in their struggle to abolish research, we do not remember seeing these faddists quite so taken back as they were a week or two ago at Clifton, when Mr. Richardson Cross, a medical man of the town, dared to cross swords with the great Mr. Stephen Coleridge himself. It must have wrung Mr. Coleridge's withers to hear opinions diametrically opposed to his own cheered by an audience called together for a very different purpose. Like Balaam of old, they failed to curse sufficiently. It is an unpleasant and an onerous task for a medical man to take on himself to defend unpopular opinions in his own neighbourhood, and it is all the more credit to those who are found, like Mr. Richardson Cross, willing and able to accept the challenge thrown down by defamers of the medical profession. By the simple example of the present researches into cancer,for which experiments on animals are necessary, Mr. Cross was able to convince his hearers of the justifiability of such experiments, and he was also able to point out a few of the more scandalous misrepresentations to which our profession is exposed at the hands of anti-vivisectionists.

The State and Moral Insanity.

A case that was before the Bow Street Magistrate last week illustrates vividly the hiatus that exists between commonsense and our criminal law. The prisoner was a man of sixty-eight who had once held the position of manager of an important bank, but who had been convicted twenty-nine years ago of a certain criminal offence. He had then been sentenced to penal servitude for life, but after serving fifteen years of his term he was released on ticket-of-leave. Soon afterwards he was again arrested on a similar charge, and Mr. Justice Wills, in passing a sentence of two years' hard labour, expressed the hope that he would never be allowed out again. Having undergone this punishment he was kept at penal servitude till recently, through the intervention of Lord Alverstone and the Salvation Army he was released on condition that he would live in one of the Army cottages at Bermondsey. The wretched man was soon discovered committing the same offence, and on his appearance at Bow Street the magistrate recommitted him to penal servitude for the rest of his life. Is it possble to conceive of a more hopeless vacillation between undue severity and undue lenity ? The " criminal," it is obvious, is as morally insane, as little capable of self-control in the particular matter he offends in, as a kleptomaniac or homicidal lunatic. The last-named, being dangerous, is provided with a seminary in which to pass his days, but poor Smith, the broken-down bank-manager is given penal servitude for life. Is it too much to hope that the Home Office have an expert at their disposal, who can advise them how this miserable creature ought to be dealt with, and how much moral reformation is to be expected of penal servitude in such a case ?

The Future of Nursing.

That the question of the status of nursing as a profession is attracting some amount of public attention at present is shown by the admission to the pages of the current number of the *Westminster Review* of an article on the subject by Dr. Joseph Oldfield. He, like many others, is perturbed at the inconveniences and abuses arising from the present unregulated condition of the " nursing profession," though it may be that he takes these matters somewhat too seriously. He frets himself unnecessarily, too, at the lack of sympathy he observes in the present-day nurse, a lack that " can never be made up by miles of pink gauze, or tons of blue wool, or thousands of clinical thermometers boldly carried by regiments of women in scarlet-lined cloaks." Gibes of this sort hardly help to the solution of any problem ; nor will any amount of sympathy abolish the need for gauze and wool. Dr. Oldfield, however, has his solution to offer. Having brushed away the tentative suggestions of the House of Commons Select Committee as lacking in broadness and statesmanship, he suggests the incorporation of a Royal College of Nursing, with the power to grant " degrees in nursing, just as there are degrees in medicine." The function of the college would apparently be to examine nursing probationers every quarter—save the mark ! during their training in hospitals—any hospital of twenty-beds apparently will do. We fail to see in what way knowledge of nursing can be tested by a " Royal College of Nursing," apart from the hospitals, or why, if the principle be adopted in the case of nursing, it should not be equally applicable to every other calling in life.

Veronal Poisoning.

Veronal is rapidly coming into favour as an hypnotic, and indeed possesses so many advantages amongst drugs of its class that it is likely to find a permanent niche in the therapeutic gallery. So far instances of its unfavourable action have been few, but in *The Canadian Practitioner* for this month, Dr. T. S. Farncomb relates a case that occurred in his practice, in which it proved fatal to the patient. Unfortunately it was not possible to ascertain what dose was taken, but there is no reason to suppose it was an extravagantly large one. The patient was a gentleman who had consulted a physician on account of insomnia, and was advised to take veronal in powders. For two months the drug seems to have acted well, and as he was about to go away for a visit he bought two one-ounce boxes of veronal, from which he weighed out his own doses. On October

28th, having had no sleep the previous night, he measured himself out a dose in the morning and lay down to rest. He soon became drowsy, and his wife left him till 6 p.m., as she had engagements to fulfil. On her return her little boy told her that his father had taken another dose early in the afternoon, and when she went up to the bedroom, she was alarmed to find him unconscious. Dr. Farncomb was sent for, and on his arrival, he found the patient could not be roused. The temperature was normal; the pulse 72; respirations, 18; breathing deep but not stertorious; pupils normal in size and sensitive to light; the conjunctival reflex natural; and the muscles easily thrown into contraction by electrical stimulative. The patient could swallow perfectly well. The next morning the temperature was slightly raised, and the patient could be roused so far as to speak intelligently. The following day the stupor deepened, and the respiration became rather noisy. The next day the temperature rose to 103° and signs of consolidation appeared at the right base. The patient died the following day, the stupor still being profound and the consolidation more extensive. Whether the pneumonia was in any way related to the veronal is not clear, but from the deep stupor it cannot be doubted that the drug was primarily responsible for the patient's death.

Progress in Cancer Research.

The man in the street who likes to see immediate results is beginning to grow discontented that after some three years' work the investigators under the Imperial Cancer Research Fund have not yet discovered the "cause of cancer." To anyone, however, who studies carefully, the results of the working of the Research Fund, or the admirable remarks of Dr. Bashford on the subject in a recent number of a contemporary (*British Medical Journal*, December 9th, 1905), the actual ground covered, and the actual findings thereon, will be sure to be more than satisfactory. It is, perhaps, true that the work so far is negative in that it has rather cleared the ground than erected edifices, but the former process is no less necessary than and is an essential preliminary to the latter Perhaps the most important point established by Dr. Bashford and his colleagues, in opposition to long-cherished beliefs, is that cancer is not a disease confined to man much less to civilised man. It occurs in mammals, birds, and fishes. Moreover, it has been shown that within certain limitations, cancer is transmissible from animal to animal, and the limitations are no less interesting and important than the fact. While it is easy to transplant a malignant tumour from one animal to another of the same variety, it is impossible to graft it on an animal of a different variety, much less on one of a different species. Thus, cells from a cancer of a wild mouse will not grow in a tame mouse, and it is with difficulty cancer cells from a German mouse grow in an English mouse; and cancer from a mouse will grow in no other animal. These points show a marked contrast with everything that is known of the phenomena of ordinary infection. Another important fact established by the Cancer Research workers is that cancer, in animals as in man, is a disease of old age.

Correspondence.

HALF-FEES AND CO-OPERATIVE SOCIETIES.

To the Editor of The Medical Press and Circular.

Sir,—My attention having been drawn to a comment in your paper of December 20th *re* "Half Fees and Co-operative Societies," I write to state that the arrangement made by me some years ago with the Civil Service Supply Association was to the effect that any member wishing to consult a specialist in throat and ear diseases could obtain my name and address from the secretary, and could be seen by me for one instead of two guineas the first visit; subsequent visits one guinea, and operation fees, of course, according to what was the nature of the operation required.

The arrangement appeared to me at the time I made it not an unusual one, there being an oculist of high position occupying a similar post.

No names whatever appear in the Stores book, merely a notice to the effect that the name of a specialist can be given to members on application. I am at a loss to understand that there has been an infringement of professional etiquette, but as there may be a feeling that such an arrangement is unwise, I propose to resign the appointment forthwith.

I am, Sir, yours truly,

Philip de Santi.

15, Stratford Place, W.

[We have pleasure in publishing the above letter, which frankly acknowledges an arrangement with the Civil Service Co-operative Stores, and an explanation of his attitude with regard to the affair. There are various reasons why such an arrangement would be condemned by the medical profession, and we are glad to learn that Mr. de Santi has now definitely withdrawn his name. So far as oculists are concerned, we believe that one gentleman was excluded from the Ophthalmological Society in the belief that he held a similar position with regard to certain Stores. The society in question, however, is somewhat erratic in its ethical justice, for it retained a member who acted as examiner for the Spectacle Makers' Society, and signed the diploma of that body. In spite of the utilitarian wave that has threatened many of our professional usages, we hold that medical men will best maintain their dignity by sternly rejecting specious overtures from trade societies. When any doubt exists as to the advisability of any given step, it will be wise to write to Dr. Bateman, Secretary of the Medical Defence Union, whose valuable experience is always at the service of the profession.—Ed.]

"THE LOGIC OF THOUGHT READING."

To the Editor of The Medical Press and Circular.

Sir,—With reference to the editorial note on this subject in your issue of December 13th, I should like to point out that many factors are concerned in the present-day development of credulity and incredulity among every class of the people, including those who claim to stand foremost among the educated and cultivated. There is nowadays manifest among every class a truly marvellous capacity to accept false evidence. The more impossible the more eagerly often are the claims of pseudo-scientists and blatant charlatans taken as true, whilst some cults such as Christian Science and Esoteric Buddhism apparently require before all things of their votaries that they shall discard science, despise logical reasoning, and subscribe to creeds in virtue merely of the fact that they are obviously incredible or impossible. It seems to me that among the factors contributing to the formation of these muddle-headed conditions the public teachings of some distinguished men of science take a considerable part. Look at Sir Oliver Lodge, for instance. If anyone will take the trouble to read the address on "The Scientific Attitude to Marvels" which he contributed to the Psychological Research Society on December 11th, and which is reported in the *Times* of the 12th, they will, I think, agree with me. It seems that the society is now nick-named the Society for Spookical Research, its chief function being to receive seriously and discuss solemnly spookical stories from the kind of people who are too "scientific" to believe in vulgar ghosts, yet cannot get on quite comfortably without something to make them shudder at on dark winter evenings. Among all the phenomena which science strives to elucidate those of psychology are notoriously the most difficult. To record the plainest and simplest observation of any real value from the scientific point of view, even in the concrete physical phenomena of nature, is as a rule, beyond the power of any save those properly educated in science. How much more difficult does it become for the uninstructed or imperfectly instructed tyro to make any observation of the least value as regards the workings of his own mental processes or of those of his friends. Imagine Sir Oliver Lodge talking to a popular audience about "movements without contact—sounds and luminous appearances," and other "things" which ought not to be regarded as "supernatural," but "simply as præter-normal or perhaps super-normal, or at any rate unusual, and at the most weird." It seems to me, Sir, that nothing but mischief can come from directing attention to or perhaps fixing attention upon phenomena which are in most cases mainly pure illusions of the senses; and I suggest that such illusions may be developed in weak-minded individuals to their great detriment when their thoughts are turned towards them by the teachings of highly authoritative men of science like the distinguished Principal of Birmingham University.

I am, Sir, yours truly,
A Psychological Student.

December 15th, 1905.

ASEPTIC MANAGEMENT OF THE UMBILICAL CORD.

To the Editor of The Medical Press and Circular.

Sir,—Having read the short article under the above heading in your last issue, may I state that in 1902, I drew attention to an improved method of treating the funic stump and wrote the following :—"The time-honoured plan of ligature and scorched rag as a dressing for the funic stump I have considered could be improved upon, more especially as it is not at all free from risk. Eroess (of Buda Pest) from a study of the temperature of 1,000 infants born in the obstetric clinic there comes to the conclusion 'That septic infection from the navel in association with the detachment of the umbilical cord is a frequent cause of fever, and an important element in the mortality of infants.' Waddington reports two cases (*American Medical Association*) of 'Tetanus-neonatorum' which began to recover immediately after the application of thorough antisepsis to the granulating protuberance at the umbilicus; evidently caused by absorption from the sloughing cord before separation. Baginsky declares himself 'in favour of dry dressing cotton and iodoform. Carbolic acid, he states, is dangerous, for only a slight abrasion of navel is necessary to cause toxic symptoms and the toxæmia is usually fatal.'"

I then described a simple form of clamp, made for me by Messrs. Arnold (Smithfield) and pictured in their (new) catalogue (page 823), which by keeping the stump of funis from contact with infant's abdomen, I have always found to answer completely and prevent any risk of infection, the clamp with its contents dropping off in the usual time.

The simplicity of this form of clamp described and illustrated in *The Hospital Gazette* for September, 1902, will be found in practice cleanly and efficient.

I am, Sir, yours truly,
London, W. Alexander Duke.

NEW BOOKS AND NEW EDITIONS.

The following have been received since the publication of our last list:—

Bailliere, Tindall and Cox (London).
  Surgical Diseases of the Dog and Cat. By Frederick T. G. Hobday, F.R.C.V.S. Second Edition, revised and enlarged. With 242 illustrations. Pp. 366. Price 10s. 6d. net.
John Bale, Sons and Danielsson, Ltd. (London).
  The Diagnosis of Tuberculosis of the Lung, with special reference to the early stages. By Dr. R. Turban. With an introduction by Sir Dyce Duckworth, M.D. Translated by Egbert C. Morland, M. B., B.Sc., Lond. Pp. 135. Price 5s. net
J. and A. Churchill (London).
  Year-Book of Pharmacy. Comprising abstracts of papers contributed to British and foreign journals from July 1, 1904, to June 30, 1905, with the transactions of the British Pharmaceutical Conference at Brighton, July, 1905. Edited by J. O. Braithwaite, E. Saville Peek, M.A., and Edmund White, B.Sc. Pp. 538.
W. B. Saunders and Co. (Philadelphia).
  Abdominal Operations. By B. G. A. Moy han, M.S., Lond., F.R.C.S. Illustrated. Pp. 694. Price 28s. net.
  Anatomy and Physiology for Nurses. By Le Roy Lewis, M.D. Illustrated. Pp. 317. Price 7s. 6d. net.
Verlag Von S. Kaigke, Karlstrasse, 15 (Berlin).
  Grundriss eines Systems der Medizinischen Kulturgeschichte. Von Dr. Julius Pag Pp. 112. Price M2.80.
  Allgemeine Pathologisch-Anatomische Diagnostik. Von Dr. R. Oestreich. Pp. 323. Price M6.
  Auleitung zur Diagnose und Therapie der Kehlkopf-Nasen-und Ohrenkraukheiten. Von Dr. Richard Kayser. Pp. 186. Price M4.80.
  Operations-Vademecum, fur den Praktischen Aszt. Von Prof. Dr. E. Leser. Illustrated. Pp. 186. Price M5.
  Gynakologische Diagnostik. Von Dr. Max Henkel. Illustrated. Pp. 356. Prices M6.40.

Trinity College, Dublin.

The following candidates passed the Final in Medicine during Michaelmas term, 1905.—George E. Nesbitt, Howard English, John W. Burns, Robert B. Jackson, James M. Harold, Cyril H. M'Comas and Hubert R. R. Fowler (equal), Thomas L. de Courcey, Alfred C. Elliott, Carlile Kelly, Edward D. Atwell; Benjamin Johnson, William C. MacFetridge and William I. Thompson (equal), Daniel M. Corbett, John B. B. Whelan, Ernest C. Phelan, Henry D. Drennan, Thomas T. H. Robinson.

For the Diploma in Public Health, Parts I. and II. were passed by Lionel F. Smith and Arthur M. MacLaughlin.

DUBLIN.

The following gentlemen have been appointed extern examiners by the board of Trinity College, for the ensuing term of two years:—

Clinical Medicine, Dr. A. R. Parsons; Practice of Medicine, Dr. Wallace Beatty; Clinical Surgery, Sir A. Chance, F.R.C.S.I.; Ophthalmology, Mr. Louis Werner, M.B.; Midwifery and Gynæcology. Dr. R. D. Purefoy; Mental Diseases, D. H. K. Abbott; Pathology, Prof. J. Lorrain Smith, M.D.; Institutes of Medicine, Prof. C. S. Sherrington, M.D.; Anatomy, Prof. Symington, M.D.; Dental Surgery and Mechanics, Dr. A. W. W. Baker and Mr. G. W. Yeates, M.B.; Dental Anatomy, Mr. W. G. T. Story, M.D.; Vital Statistics and Public Health Acts, The Registrar General; Sanitary Engineering, Mr. W. Kaye Parry M.A.

His Majesty the King has been pleased to grant Mr. Charles A. Ballance, F.R.C.S., permission to accept and wear the Insignia of the Third Class of the Royal Order of the Crown, recently conferred upon him by the German Emperor.

Professor Sir Henry Littlejohn has tendered his resignation of the Chair of Forensic Medicine in the University of Edinburgh, which he has occupied for the last nine years. Sir Henry obtained his M.D. degree sixty years ago. The LL.D.Edin. was bestowed on him in 1893, and a Knighthood in 1895.

Notices to Correspondents, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, to avoid the practice of signing themselves "Reader," "Subscriber" 'Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Contributors are kindly requested to send their communications if resident in England or the Colonies to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

DRUG IDIOSYNCRASIES IN THE BRITISH PHARMACOPŒIA.

To the Editor of the Medical Press and Circular.

Sir,—Will you permit me to correct, on one point, your brief report of my paper recently read before the Therapeutical Society. My suggestion was not that further "cautons" in relation to doses should be introduced into the Preface to the Pharmacopœia, but that the qualifications already exisiting there should receive more adequate recognition.
63 Harley Street, W., Dec. 21st. Yours faithfully, G. O. G. Hawthorne

Dr. S. K. M. (Salop).—Christmas time is always a time of tension in the journalistic world. We hope, however, to send your proofs a few days later. The article will appear in full and we are indebted to you for the exclusive publication of so valuable a scientific contribution.

Sanitation.—One of the best books on the subject is "Hygiene" by Parkes and Kenwood.

B.C. (Cantab).—The danger arising from apparatus for the rapid heating of water in bath rooms is due to the following causes. The chamber to start with is small and ill-ventilated so that its oxygen is rapidly consumed by the gas flame used for heating. At the same time a large quantity of carbonic acid and other deleterious gases is thrown off. The result under such circumstances is that the unfortunate bather is plunged into a poisonous atmosphere by which he is apt to be speedily overcome. The ordinary bathroom, by the way, is destitute of a bell by which even a fainting man might summon aid.

S. Samuelson (London, W.)—We cannot advise you what physician to consult. It may be permissible to hint, however, that not all cases called "diabetes" are really of that nature. Any experienced physician of standing would be able to give you a sound opinion.

C. S. M. (Exeter).—The statistics are only approximate; they would naturally be less reliable in the large Indian cities where the native populations are more or less nomadic in their habits. In Calcutta, the population is officially given as 847,796; Bombay 776,006, and Madras 509,346; but it is generally considered that these numbers fall short of the actual population in each case.

Assistant Superintendent.—The work by Bianchi about which you ask for information, has been translated by Dr. Jas. K. Macdonald and now makes its appearance in English dress under the title of a "Text-Book of Psychiatry," the work is of immense value to those engaged in the treatment of the insane.

F. E. R. (Derby).—The law is clear on the subject, whether applied to the individual or combination of persons, prohibiting anyone to take charge of the insane or idiots unless specially licensed under the Act.

W. E. Foster.—Stones in the kidneys occasionally reach a very great size: an ever-present danger is rupture. In one case death followed rupture of the kidney in a football player who suffered from large unsuspected renal calculus.

Vacancies.

Bristol Royal Infirmary.—Pathologist, Bacteriologist, and Director of Clinical Laboratories. Salary £250 per annum. Applications to W. E. Budgett, Secretary and House Governor.

Seamen's Hospital Society.—
Two Assistant Physicians.
One Assistant Physician or Surgeon for Diseases of the Throat, Nose, and Ears.
Applications to P. Michelli, Secretary, Seamen's Hospital Society, Greenwich, S.E. (See Advt.).

Nottingham General Hospital.—Assistant House Surgeon. Salary £100 per annum, with board, lodging, and washing in the hospital. Applications to the Secretary.

Ryde—Royal Isle of White County Hospital.—Resident Male House Surgeon. Salary £90 per annum. Applications to the Secretary.

Tiverton, Devonshire.—Infirmary and Dispensary.—House Surgeon and Dispenser. Salary £80 per annum and all found. Applications to Arthur Fisher, Hon. Secretary.

University of Birmingham.—Demonstratorship in Anatomy. Salary £175 per annum. Applications to George H. Morley, Secretary.

Parish of Saint Leonard, Shoreditch.—Second Assistant Medical Officer. Salary £100 per annum, with rations, washing and furnished apartments. Applications to Robert Clay, Clerk to the Guardians, Clerk's Office, 213 Kingsland Road, N.E.

National Hospital for the Paralysed and Epileptic, Queen's Square, Bloomsbury, London, W.C.—Resident Medical Officer. Salary £100 a year, with board and residence. Applications to Godfrey H. Hamilton, Secretary.

Seamen's Hospital Society.—Pathologist. Salary £100 per annum Applications to P. Michelli, Secretary.

Chelsea Hospital for Women, Fulham Road, S.W.—Resident Medical Officer. Salary £80 per annum. Applications to Herbert H. Jennings, Secretary.

London Fever Hospital, Liverpool Road, N.—Resident Medical Officer Salary £250 per annum, with board and residence. Applications to the Secretary.

Appointments.

Burgess, A. H., F.R.C.S.Eng., M.B., M.Sc.Vict., Assistant to the Professor of Systematic Surgery in the Victoria University of Manchester.

Fletcher, H. N., M B., Ch.B., F.R.C.S.Edin., Junior Resident Medical Officer at St. Mary's Hospital, Whitworth Street, Manchester.

Goldsmith, B. K., M.B., Ch.B.Edin., D.P.H., House Surgeon at Clifford Street Hospital, Manchester.

Harrison, Percy Ernest, L.R.C.S., L.R.C.P.Irel., Assistant House Surgeon at the Stockport Infirmary.

Heslop, J. W., M.B., B S.Durh., M.R.C.S., L.R.C.P.Lond., Surgical Registrar to the Royal Infirmary, Newcastle-on-Tyne.

Jackson, F. D. Selmes, M.R.C.S., L.R.C.P.Lond., House Physician at the Evelina Hospital for Children, S.E.

Jordan, Alfred C., M.D.Cantab., Medical Officer to the Electrical Department of the Metropolitan Hospital.

Ralphs, F. G., M.B., Ch.B.Vict., Senior Resident Medical Officer at St. Mary's Hospital, Whitworth Street, Manchester.

Rew, George R., M.R.C.S., L.R.C.P.Lond., Assistant House and Visiting Surgeon at Stockport Infirmary.

Wilson, David, M.R.C.S., L.R.C.P.Lond., Assistant House Surgeon at the Evelina Hospital for Sick Children, S.E.

Births.

Hearnden.—On Dec. 21st, at St. Ives, Hunts, the wife of Hamilton Hearnden, M.R.C.E., L.R.C.P.L., of a daughter.

Deaths.

Blount.—On Dec. 23rd, George Bertie Clavell Blount, late of The Limes, East Molesey, M.R.C.S., L.R.C.P., second son of George Bouverie Blount, of Northchurch Rectory, Berkhampstead, aged 33.

De Crespigny.—On Dec. 21st, Beckenham, Grace Caroline, daughter of the late Dr. Eyre Champion de Crespigny, Bombay Medical Service.

Kinsey.—On Dec. 21st, at 3, Clifton Gardens, Maida Hill, London, Ann, widow of Robert Bancroft Kinsey, F.R.C.S., Deputy Inspector-General of Hospitals, Bengal, aged 76.

OPERATIONS—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopædic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Gt. Ormond Street, (9.30 a.m.), Gt. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynæcological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopædic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St George's (1 p.m.), St. Mary's (1 p.m.) Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.35 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.) Samaritan (Gynæcological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopædic (2 p.m.), City Orthopædic (4 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.) Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.) Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).

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